Oxervate

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ Date: _____
Patient's ID: _____ Patient's Date of Birth: _____
Physician's Name: _____
Specialty: _____ NPI#: _____
Physician Office Telephone: _____ Physician Office Fax: _____
Request Initiated For: _____

1. What is the diagnosis?
   ❑ Neurotrophic keratitis
   ❑ Other _____
2. What is the ICD-10 code? _____
3. What is the severity of the neurotrophic keratitis? ❑ Stage 1 ❑ Stage 2 ❑ Stage 3 ❑ Other _____
4. Did the patient experience persistent epithelial defects (PED) or corneal ulceration of at least 2 weeks duration refractory to one or more conventional non-surgical treatments (e.g., preservative free artificial tears)?
   ❑ Yes ❑ No
5. Does the patient have evidence of decreased corneal sensitivity (less than or equal to 4 cm using the Cochet-Bonnet aesthesiometer) within the area of the PED or corneal ulcer and outside of the area of the defect in at least one corneal quadrant? ❑ Yes ❑ No
6. Has the patient received a previous course of Oxervate in the affected eye?
   ❑ Yes ❑ No *If No, no further questions*
7. Is the patient currently receiving treatment in the affected eye? ❑ Yes ❑ No
8. How many weeks of Oxervate therapy has the patient received for the affected eye? _____ weeks

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature Date (mm/dd/yy)

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization. Fax: 1-866-249-6155

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization. Fax: 1-866-249-6155