US Family Health Plan
Prior Authorization Request Form for
cenegermin-bkbj ophthalmic solution **(Oxervate)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization is for one time, for 8 weeks. Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:	_____	Physician Name:	_____
Address:	_____	Address:	_____
	_____		_____
Sponsor ID #	_____	Phone #:	_____
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Does the patient have a documented diagnosis of stage 2 or 3 neurotrophic keratitis?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Is this medication being prescribed by a cornea specialist or ophthalmologist?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Is the patient 2 years of age or older?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Will the patient remove contact lenses prior to administration and reinsert contact lenses no sooner than 15 minutes after the dose?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[30 August 2019]