Texas Standard Prior Authorization Form Addendum

Molina Healthcare of Texas

Oxervate (cenegermin-bkbj) (Medicaid)

This fax machine is located in a secure location as required by HIPAA Regulations. Complete / Review information, sign, and date. Fax signed forms to Molina Pharmacy Prior Authorization Department at **1-888-487-9251**. Please contact Molina Pharmacy Prior Authorization Department at **1-855-322-4080** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Oxervate (Medicaid).

Drug Name (select from list of drugs shown / provide drug information)
OXERVATE 0.002% EYE DROP

Patient Information	
Patient Name:	
Patient ID:	
Patient DOB:	

Prescribing Physician	
Physician Name:	
Physician Phone:	
Physician Fax:	
Physician Address:	
City, State, Zip:	

Diagnosis:	ICD Code:
Directions for administration:	

*****Please include all relevant clinical notes, lab work, medication history and any other applicable documentation.**

Please circle the appropriate answer for each question.

1. Is the requested drug required per court order? (court order required) Y N
   If the answer to this question is yes, approved for 30 days.
   If the answer to this question is no, go to question 2.

2. Is the patient greater than or equal to 2 years of age? Y N
   If the answer is yes, go to question 3.
   If the answer is no, denied.

3. Does the patient have a diagnosis of neurotrophic keratitis in the last 730 days? Y N
   If the answer is yes, go to question 4.
   If the answer is no, denied.

4. Has the patient been previously treated with cenegermin in the affected eye? ` Y N
   If the answer is yes, go to question 5.
   If the answer is no, go to question 6.

5. Has the patient received greater than or equal to 56 days therapy? Y N
   If the answer is yes, denied.
   If the answer is no, go to question 6.

6. Is this request for a non-preferred drug? Y N
   If the answer is yes, go to question 7.
   If the answer is no, approved for 30 days.

7. Has the patient failed a treatment trial with at least 1 preferred agent? Y N
   If the answer is yes, approved for 30 days.
   If the answer is no, go to question 8.

8. Is there a documented allergy or contraindication to preferred agents in this class? Y N
   If the answer is yes, approved for 30 days.
   If the answer is no, go to question 9.

9. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions? Y N
   If the answer is yes, approved for 30 days.
   If the answer is no, denied.

Comments:

I affirm that the information given on this form is true and accurate as of this date.

_____ _____

Prescriber (or Authorized) Signature Date