

# NEUROTROPHIC KERATITIS PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

**Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.**

**The following documentation is REQUIRED.** Incomplete forms will be returned for additional information. For formulary information please visit [www.myprime.com](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermy meds.com](http://covermy meds.com) to begin using this free service.

**What is the priority level of this request?**

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

**Today’s Date:** \_\_\_\_\_

**PATIENT AND INSURANCE INFORMATION**

**Date of Service (if differs from Today’s Date):** \_\_\_\_\_

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:		Patient Telephone:
Member ID Number:	Group Number:		

**PRESCRIBER/CLINIC INFORMATION**

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

Patient’s Diagnosis- ICD code plus description: <input type="checkbox"/> Neurotrophic keratitis (NK) <input type="checkbox"/> Other (ICD code, plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

**For all requests:**

1. Is the patient currently treated with the requested agent? .....  Yes  No
2. Does the patient have any FDA labeled contraindications to the requested agent? .....  Yes  No  
 If yes, please specify FDA labeled contraindications: \_\_\_\_\_
3. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., optometrist, ophthalmologist), or has the prescriber consulted with a specialist in the area of the patient's diagnosis? .....  Yes  No
4. Does the patient have stage 2 [persistent epithelial defect (PED)] or stage 3 (corneal ulcer) NK? .....  Yes  No
5. Has the patient been previously treated with the requested agent in the affected eye(s)? .....  Yes  No  
 If yes, did the patient have complete corneal healing in the previously treated eye(s)? **Medical records are required** .....  Yes  No  
 If yes, has the patient had a recurrence of neurotrophic keratitis (NK) that requires another treatment course? **Medical records are required** .....  Yes  No
6. Has the patient’s PED and/or corneal ulcer been present for at least 2 weeks? .....  Yes  No
7. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer? .....  Yes  No
8. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer? **Please note, chart notes are required** .....  Yes  No
9. If yes to either of the previous two questions, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration? .....  Yes  No

**Please continue to the next page.**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
<p>10. Has the patient's NK been refractory to at least ONE conventional non-surgical treatment (i.e., preservative-free lubricant eye drops or ointment, discontinuation of preserved topical agents that can decrease corneal sensitivity, therapeutic soft contact lenses, topical autologous serum application, botulinum A toxin treatment)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, does the patient have an intolerance or hypersensitivity to at least ONE conventional non-surgical treatments for NK?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please explain intolerance/hypersensitivity: _____</p> <p>_____</p> <p>If no, does the patient have an FDA labeled contraindication to ALL conventional non-surgical treatments for NK?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please specify FDA labeled contraindication: _____</p> <p>_____</p> <p>11. Does the patient have decreased corneal sensitivity within the area of the PED or ulcer and outside the area of defect in at least one corneal quadrant?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Does the patient have ocular surface disease associated with or in conjunction to NK? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, have the ocular surface disease been properly treated? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Will the patient be using the requested agent in combination with a topical ophthalmic NSAID? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Does the patient have an active ocular infection or active ocular inflammation not related to NK in the affected eye?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Does the patient have severe blepharitis and/or severe Meibomian gland disease in the affected eye? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Does the patient have a history of any ocular surgery in the affected eye within the past 90 days that has not been determined to be the cause of NK? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>17. Does the patient have a corneal perforation, ulceration involving the posterior third of the corneal stroma, or corneal melting?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. Does the patient have bilateral NK? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>19. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). <b>Please note, documentation may be required:</b> _____</p> <p>_____</p> <p>_____</p>			
<p><b>Please fax or mail this form to:</b>  Prime Therapeutics LLC  Clinical Review Department  2900 Ames Crossing Road Suite 200  Eagan, MN 55121</p> <p><b>TOLL FREE</b></p> <p><b>Phone:</b> _____ <b>Fax: 877.243.6930</b></p> <p><b>BCBSIL: 800.285.9426</b></p> <p><b>BCBSMT: 888.723.7443</b></p> <p><b>BCBSNM: 800.544.1378</b></p> <p><b>BCBSOK: 800.991.5643</b></p> <p><b>BCBSTX: 800.289.1525</b></p>		<p><b>CONFIDENTIALITY NOTICE:</b> This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.</p>	