PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS

Miebo - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Miebo - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Miebo (perfluorohexyloctane ophthalmic solution)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

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

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is this request for continuation of therapy? Y N

[Note: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]

[If no, then skip to question 3.]

2. Has the patient had a beneficial response to treatment? Y N _____

	[Note: Documentation must be submitted.]		
	[No further questions.]		
3.	Is the patient 18 years of age or older?	Y N	
	[If no, then no further questions.]		
4.	Does the patient have a diagnosis of dry eye disease (DED), confirmed by at least one positive diagnostic test result using one of the following: A) Tear Osmolarity, B) Tear Film Breakup Time, C) Schrimer Tear Test, D), Ocular Surface Staining?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
5.	Has the patient experienced an inadequate response, or does the patient have a contraindication to at least two formulary artificial tear products?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
6.	Has the patient experienced an inadequate response, or does the patient have a contraindication to generic cyclosporine ophthalmic emulsion (generic Restasis)?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
7.	Is the requested drug being prescribed by, or has the prescriber consulted with, an ophthalmologist?	Y N	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date