

Prior Authorization Request Form for Cyclosporine  
0.05% Ophthalmic Emulsion (Restasis)



**JOHNS HOPKINS**  
HEALTH PLANS

7231 Parkway Drive, Suite 100  
Hanover, MD 21076

**Fax completed form and applicable progress notes to: (410) 424-4037**

## USFHP Pharmacy Prior Authorization Form

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

**Questions?** Contact the Pharmacy Dept at (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

LASIK surgery would approve for 3 months, all other indications would be approved for lifetime.

**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. Is the requested medication being prescribed by an ophthalmologist or optometrist?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
2. Will the requested medication be used in combination with Xiidra or Cequa?	<input type="checkbox"/> Yes <b>STOP</b> Coverage not approved	<input type="checkbox"/> No Proceed to question 3
3. Is the requested medication being prescribed for LASIK associated dry eyes?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No Proceed to question 5
4. Did the LASIK surgery occur within the last THREE Months? <i>Note that therapy is limited to a maximum of THREE months of therapy after the procedure.</i>	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
5. For what indication is the requested medication being prescribed?	<input type="checkbox"/> Moderate to Severe Dry Eye Disease – Proceed to question 6 <input type="checkbox"/> Graft rejection/graft versus host disease (GvHD) - <b>Sign and date below</b> <input type="checkbox"/> Corneal transplant - <b>Sign and date below</b> <input type="checkbox"/> Atopic keratoconjunctivitis (AKC) - <b>Sign and date below</b> <input type="checkbox"/> Vernal keratoconjunctivitis (VKC) - <b>Sign and date below</b> <input type="checkbox"/> Other – <b>STOP</b> Coverage not approved	
6. Has the patient had positive symptomology screening for moderate to severe dry eye disease from an appropriate measure?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
7. Has the patient had at least one positive diagnostic test (for example, Tear Film Breakup Time, Osmolarity, Ocular Surface Staining, Schirmer Tear Test)?	<input type="checkbox"/> Yes Proceed to question 8	<input type="checkbox"/> No <b>STOP</b> Coverage not approved

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<b>8. Has the patient tried and failed at least 1 month of one ocular lubricant used at optimal dosing and frequency (for example, carboxymethylcellulose [Refresh, Celluvisc, Thera Tears, Genteal, etc ], polyvinyl alcohol [Liquitears, Refresh Classic, etc], or wetting agents [Systame, Lacrilube])?</b>	<input type="checkbox"/> Yes Proceed to question <b>9</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>9. Has the patient tried and failed at least 1 month of a different ocular lubricant that is non-preserved at optimal dosing and frequency (for example, carboxymethylcellulose, polyvinyl alcohol, etc.)?</b>	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No <b>STOP</b> Coverage not approved

Coverage is not approved for off label uses such as, but not limited to: Pterygia, blepharitis, ocular rosacea, and contact lens intolerance.

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

\_\_\_\_\_

Prescriber Signature

\_\_\_\_\_

Date

[27 Sep 2023]

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: ____ month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: