

TRICARE Prior Authorization Request Form for
varenicline tartrate (**Tyrvaya**)



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.

Prior authorization approval expires after 1 year. For renewal of therapy an initial Tricare prior authorization approval is required.

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

1	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 prescribed by an ophthalmologist or optometrist?	<input type="checkbox"/> Yes Proceed to question 2	<input type="checkbox"/> No STOP Coverage not approved
2. Has the patient received this medication under the TRICARE benefit in the last 6 months? Please choose "No" if the patient did not previously have a TRICARE approved PA for Tyrvaya.	<input type="checkbox"/> Yes (subject to verification) Proceed to question 3	<input type="checkbox"/> No Proceed to question 5
3. Does the patient have documented improvement in ocular discomfort?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
4. Does the patient have documented improvement in signs of dry eye disease?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
5. Is the patient greater than or equal to 18 years of age?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved
6. What is the indication or diagnosis?	<input type="checkbox"/> Dry eye disease – Proceed to question 7 <input type="checkbox"/> Other - STOP Coverage not approved	
7. Has the patient had positive symptomology screening	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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for dry eye disease from an appropriate measure?	Proceed to question 8	STOP Coverage not approved
8. 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 9	<input type="checkbox"/> No STOP Coverage not approved
9. Has the patient had 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 [Systane, Lacrilube])?	<input type="checkbox"/> Yes Proceed to question 10	<input type="checkbox"/> No STOP Coverage not approved
10. Was the initial trial followed by at least 1 month of a different ocular lubricant that is non-preserved at optimal dosing and frequency (for example, carboxymethylcellulose, polyvinyl alcohol)?	<input type="checkbox"/> Yes Proceed to question 11	<input type="checkbox"/> No STOP Coverage not approved
11. Has the patient had at least 3 month trial of cyclosporine (Restasis) or lifitegrast (Xiidra)?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> 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

[23 November 2021]

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: