Prior Authorization Request Form for
cyclosporine 0.09%ophthalmic (**Cequa**)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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**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.

**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 this medication being prescribed by an ophthalmologist or optometrist?** | ☐ Yes<br>Proceed to question **2** | ☐ No<br>**STOP**<br>Coverage not approved |
| **2. Does the patient have moderate to severe dry eye?** | ☐ Yes<br>Proceed to question **3** | ☐ No<br>**STOP**<br>Coverage not approved |
| *3.* **Is this a request for continuation of therapy?** *Please choose "No" if the patient did not previously have a TRICARE approved PA for Cequa* | ☐ Yes<br>Proceed to question **10** | ☐ No<br>Proceed to question **4** |
| **4. Is the patient 18 years of age or older?** | ☐ Yes<br>Proceed to question **5** | ☐ No<br>**STOP**<br>Coverage not approved |
| **5. Has the patient obtained positive symptomatology screening for moderate to severe dry eye disease from an appropriate measure?** | ☐ Yes<br>Proceed to question **6** | ☐ No<br>**STOP**<br>Coverage not approved |
| **6. Has the patient obtained AT LEAST ONE positive diagnostic test (such as Tear Film Breakup Time, Osmolarity, Ocular Surface Staining, or Schirmer Tear Test)?** | ☐ Yes<br>Proceed to question **7** | ☐ No<br>**STOP**<br>Coverage not approved |

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| | | |
|---|---|---|
| **7. Has the patient tried and failed AT LEAST ONE month of ONE ocular lubricant used at optimal dosing and frequency (such as carboxymethylcellulose [Refresh, Celluvisc, Thera Tears, Genteal, etc.], polyvinyl alcohol [Liquitears, Refresh Classic, etc.], or wetting agents [Systane, Lacrilube])?** | ☐ Yes<br>Proceed to question **8** | ☐ No<br>**STOP**<br>Coverage not approved |
| **8. Has the patient tried and failed AT LEAST ONE month of a different ocular lubricant that is non-preserved at optimal dosing and frequency (such as carboxymethylcellulose or polyvinyl alcohol)?** | ☐ Yes<br>Proceed to question **9** | ☐ No<br>**STOP**<br>Coverage not approved |
| **9. Will the patient use Restasis or Xiidra in combination with the requested medication?** | ☐ Yes<br>**STOP**<br>Coverage not approved | ☐ No<br>**Sign and date below** |
| **10. Does the patient have a documented improvement in ocular discomfort?** | ☐ Yes<br>Proceed to question **11** | ☐ No<br>**STOP**<br>Coverage not approved |
| **11. Does the patient have a documented improvement in signs of dry eye disease?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>Coverage not approved |

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

_____ _____

Prescriber Signature Date

[29 May 2019]

| **For Internal Use Only** | |
|---|---|
| ☐ Approved: | Duration of Approval: _____month(s) |
| ☐ Denied: | Authorized By: |
| ☐ Incomplete/Other: | PA#: |
| Date Faxed to MD: | Date Decision Rendered: |