TRICARE Prior Authorization Request Form for
latanoprost 0.005% ophthalmic solution (Iyuzeh)

JOHNS HOPKINS
HEALTH PLANS

7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

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 does not expire.

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 prescribed by an ophthalmologist or an optometrist?	o Yes **Proceed to question 2**	o No **STOP** **Coverage not approved**
2. Does the patient have a diagnosis of ocular hypertension or open-angle glaucoma?	o Yes **Proceed to question 3**	o No **STOP** **Coverage not approved**
3. Has the patient had a trial of appropriate duration with TWO different formulary options, from any of the following glaucoma drug classes, in combination or separately and have failed to reach intraocular pressure target goals: • **prostaglandin analogs (for example, Lumigan, Travatan, Xalatan),** • **beta blockers (for example, Timoptic),** • **alpha2-adrenergic agonists (for example, Alphagan P),** • **topical carbonic anhydrase inhibitors (for example, Azopt, Trusopt, Cosopt)?**	o Yes **Sign and Date below**	o No **Proceed to question 4**
4. Is the patient currently taking latanoprost and requires a preservative-free formulation due to experiencing adverse events?	o Yes **Sign and Date below**	o No **Proceed to question 5**

5. Is the patient on three or more different ocular medications that contain preservatives and accumulation of preservatives is a concern?	o Yes **Sign and date below**	o 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 __________

[14 February 2024]

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