TRICARE Prior Authorization Request Form for
netarsudil 0.02% ophthalmic solution **(Rhopressa),**
netarsudil/latanoprost ophthalmic solution **(Rocklatan)**

JOHNS HOPKINS MEDICINE
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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. Does the patient have a diagnosis of ocular hypertension or open-angle glaucoma?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Is the prescription written by an ophthalmologist or an optometrist?	☐ Yes Proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Will the patient be using both Rhopressa and Rocklatan at the same time?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question **4**
4. Has the patient had a trial of appropriate duration with two different formulary options, from any of the following different glaucoma drug classes, in combination or separately: prostaglandin analogs (latanoprost or bimatoprost), beta blockers (Betoptic, Betoptic-S, Ocupress, Betagan, Optipranolol), alpha2-adrenergic agonists (brimonidine, apraclonidine), topical carbonic anhydrase inhibitors (dorzolamide (Trusopt)?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**

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5. Has the patient reached intraocular pressure target goals using medications from standard therapy classes as defined by provider? (standard therapy classes include: prostaglandin analogs (latanoprost or bimatoprost), beta blockers (Betoptic, Betoptic-S, Ocupress, Betagan, Optipranolol), alpha2-adrenergic agonists (brimonidine, apraclonidine), topical carbonic anhydrase inhibitors (dorzolamide (Trusopt).	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

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

_____ _____

Prescriber Signature Date

[23 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: