TRICARE Prior Authorization Request Form for
acoltremon ophthalmic solution **(Tryptyr)**

JOHNS HOPKINS
HEALTH PLANS
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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.

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 being prescribed by an ophthalmologist or optometrist?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Is the patient 18 years of age or older?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Does the patient have signs and symptoms of dry eye disease?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Has the patient obtained positive symptomatology screening for dry eye disease from an appropriate measure?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. 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 Proceed to question **6**	☐ No **STOP** Coverage not approved
6. 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 Proceed to question **7**	☐ No **STOP** Coverage not approved

7. 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 Proceed to question **8**	☐ No **STOP** Coverage not approved
8. Has the patient had a 3 month trial of cyclosporine 0.05% (Restasis or its generics)?	☐ Yes **Sign and date below**	☐ 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

[15 July 2026]

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