TRICARE Prior Authorization Request Form for
lotilaner **(Xdemvy)**

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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 expires in 6 months; a new PA must be submitted.

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 optometrist?	☐ Yes **Proceed to question 2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have a diagnosis of Demodex blepharitis confirmed by the presence of Demodex mites on microscopic examination? **Note: Non-FDA approved uses are NOT approved, including for dry eye disease or meibomian gland dysfunction.**	☐ Yes **Proceed to question 3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have Demodex infestation with at least 10 eyelashes with collarettes?	☐ Yes **Proceed to question 4**	☐ No **STOP** **Coverage not approved**
4. Is the patient greater than or equal to 18 years of age?	☐ Yes **Proceed to question 5**	☐ No **STOP** **Coverage not approved**
5. Has the patient tried and failed an adequate treatment course with topical tea tree oil?	☐ Yes **Proceed to question 6**	☐ No **STOP** **Coverage not approved**

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6. Will the patient continue to practice good eyelid hygiene including eyelid wipes (for example, Ocusoft)?	☐ 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 _____

[14 Feb 2024]

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