Prior Authorization Request Form for
Ophthalmic Immunomodulatory Agents Subclass: Cyclosporine 0.05% Ophthalmic Emulsion (Restasis)

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. Is this drug being prescribed by an ophthalmologist or optometrist?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Restasis*	☐ Yes (subject to verification) Proceed to question **12**	☐ No Proceed to question **3**
3. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Will the requested medication be used in combination with Xiidra or Cequa?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **5**
5. Is the requested medication being prescribed for LASIK associated dry eyes?	☐ Yes Proceed to question **6**	☐ No Proceed to question **7**
6. Did the LASIK surgery occur within the last THREE Months? ***Note that therapy is limited to a maximum of THREE months of therapy after the procedure.***	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved
7. For what indication is the requested medication being prescribed?	☐ Moderate to Severe Dry Eye Disease – Proceed to question **8** ☐ Ocular graft vs. host disease - **Sign and date below** ☐ Corneal transplant - **Sign and date below** ☐ Atopic keratoconjunctivitis (AKC) - **Sign and date below** ☐ Vernal keratoconjunctivitis (VKC) - **Sign and date below** ☐ Other – **STOP** Coverage not approved	
8. Has the patient had positive symptomology screening for moderate to severe dry eye disease from an appropriate measure?	☐ Yes Proceed to question **9**	☐ No **STOP** Coverage not approved

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9. Has the patient had at least one positive diagnostic test (e.g. Tear Film Breakup Time, Osmolarity, Ocular Surface Staining, Schirmer Tear Test)?	☐ Yes Proceed to question **10**	☐ No **STOP** Coverage not approved
10. Has the patient tried and failed at least 1 month of one ocular lubricant used at optimal dosing and frequency (e.g. carboxymethylcellulose [Refresh, Celluvisc, Thera Tears, Genteal, etc], polyvinyl alcohol [Liquitears, Refresh Classic, etc], or wetting agents [Systame, Lacrilube)?	☐ Yes Proceed to question **11**	☐ No **STOP** Coverage not approved
11. Has the patient tried and failed at least 1 month of a different ocular lubricant that is non-preserved at optimal dosing and frequency (e.g. carboxymethylcellulose, polyvinyl alcohol, etc.)?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved
12. Does the patient have a documented improvement in ocular discomfort?	☐ Yes Proceed to question **13**	☐ No **STOP** Coverage not approved
13. Does the patient have documented improvement in signs of dry eye disease?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved
Coverage is not approved for off label uses such as, but not limited to: Pterygia, blepharitis, ocular rosacea, and contact lens intolerance.		

Step 3

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

_____ _____

Prescriber Signature Date

[31 July 2019]

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