PRIOR AUTHORIZATION REQUEST
Restasis and Xiidra

PATIENT: Name_____
Address:_____
City, State, Zip_____
D.O.B._____
Member ID: _____

Prescriber: Name_____
Address_____
City, State, Zip_____
Phone _____
Fax_____
NPI _____

Medication Requested: *Restasis and Xiidra* **Qty Requested: _____**

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A Please answer the following questions

1. Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?
   - θ INITIAL
   - θ CONTINUATION
2. What is the diagnosis or indication?
   - θ Keratoconjunctivitis Sicca (KCS - dry eyes)
   - θ Sjogren's syndrome
   - θ All other indications or diagnoses ***(Please Specify):*** _____
3. θ Yes θ No Is this medication being prescribed by, or in consultation with, an ophthalmologist or optometrist after completing a slit lamp evaluation?
4. θ Yes θ No Has the patient tried and failed at least TWO different types of artificial tears products used at least 4 times per day?
5. θ Yes θ No Was ONE of these products tried and failed an ointment OR other medication that contained a high viscosity ingredient (such as glycerin or propylene glycol)?

Please document the diagnoses, symptoms, and/or any other information important to this review:

_____

_____

SECTION B Physician Signature

_____ _____
PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

If you have any questions, call: 800-753-2851