maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Restasis/Xiidra

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1	Is this a request for INITIAL or CONTINUATION of therapy with the requested medication? [] Initial (If checked, go to 2) [] Continuation (If checked, go to 7)		
2	Is the patient 16 years of age or older? [If no, no further questions.]	Yes	No
3	What is the diagnosis or indication?		

If you have any questions, call:
1-888-258-8250

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[] Keratoconjunctivitis sicca (KCS - dry eyes) (If checked, go to 4)

[] Sjogren's syndrome (If checked, go to 4)

[] Other (If checked, no further questions)

4	Is this medication being prescribed by, or in consultation with, an ophthalmologist or optometrist after completing a slit lamp evaluation? [If no, no further questions.]	Yes	No
5	Has the patient tried and failed at least TWO different types of artificial tears products used at least 4 times per day? [If no, no further questions.]	Yes	No
6	Was ONE of the products tried and failed an ointment OR contain a high viscosity ingredient (such as glycerin or propylene glycol)? [No further questions.]	Yes	No
7	Has the patient responded to therapy with the requested medication?	Yes	No

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: 1-833-896-0656

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.

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