PRIOR AUTHORIZATION REQUEST

XDEMVY

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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Has the patient been treated with Xdemvy in the past six months? [If yes, no further questions.]	Yes	No
2	What is the diagnosis or indication? [] Demodex blepharitis (If checked, go to 3) [] Other (If checked, no further questions)		

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

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3	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
4	Is the medication being prescribed by or in consultation with an ophthalmologist or optometrist? [If no, no further questions.]	Yes	No
5	Has documentation been provided to show the patient has ALL of the following in at least one eye: A) More than 10 lashes with collarettes present in upper lid, B) Mild erythema of upper eyelid margin, C) Demodex density of upper/lower eyelids of 1.5 or more mites per lash? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
6	Has the patient had an inadequate response to a treatment with tea tree oil (terpinen-4-ol) and eye lid scrubs, or has a contraindication to tea tree oil (terpinen-4-ol)? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
7	Has the patient had an inadequate response to an adequate trial of an eyelid hygiene regimen? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
8	Has the patient had an inadequate response to oral ivermectin for 4 to 6 weeks, or has a contraindication to oral ivermectin? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
9	Does the requested dose exceed the Food and Drug Administration (FDA) approved label dosing for the requested indication? [Note: Dosing is 1 drop into each eye twice daily.]	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

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authorization as per Plan policy and procedures.

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