# US Family Health Plan
# Prior Authorization Request Form for
# **Ophthalmic Immunomodulatory Agents Subclass:**
# Cyclosporine 0.05% Ophthalmic Emulsion **(Restasis)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **855-273-5735**
OR
The patient may attach the completed form to the prescription and mail it to:
**Attn: Pharmacy, 77 Warren St, Brighton, MA 02135**

QUESTIONS? **Call 1-877-880-7007**

**Prior authorization for initial therapy and renewal therapy will approve for 1 time. Consecutive therapy within 120 days will continue without additional Prior authorization required. Therapy requested outside of 120 days will require additional prior authorization. For renewal of therapy an initial Tricare prior authorization approval is required.** **usfamilyhealth.org/rx-pa**

## 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<br>Proceed to question **2** | ☐ No<br>**STOP**<br>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<br>(subject to verification)<br>Proceed to question **12** | ☐ No<br>Proceed to question **3** |
| **3. Is the patient greater than or equal to 18 years of age?** | ☐ Yes<br>Proceed to question **4** | ☐ No<br>**STOP**<br>Coverage not approved |
| **4. Will the requested medication be used in combination with Xiidra or Cequa?** | ☐ Yes<br>**STOP**<br>Coverage not approved | ☐ No<br>Proceed to question **5** |
| **5. Is the requested medication being prescribed for LASIK associated dry eyes?** | ☐ Yes<br>Proceed to question **6** | ☐ No<br>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<br>**Sign and date below** | ☐ No<br>**STOP**<br>Coverage not approved |
| **7. For what indication is the requested medication being prescribed?** | ☐ Moderate to Severe Dry Eye Disease – Proceed to question **8**<br>☐ Ocular graft vs. host disease - **Sign and date below**<br>☐ Corneal transplant - **Sign and date below**<br>☐ Atopic keratoconjunctivitis (AKC) - **Sign and date below**<br>☐ Vernal keratoconjunctivitis (VKC) - **Sign and date below**<br>☐ 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<br>Proceed to question **9** | ☐ No<br>**STOP**<br>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<br>Proceed to question **10** | ☐ No<br>**STOP**<br>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<br>Proceed to question **11** | ☐ No<br>**STOP**<br>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<br>**Sign and date below** | ☐ No<br>**STOP**<br>Coverage not approved |
| **12. Does the patient have a documented improvement in ocular discomfort?** | ☐ Yes<br>Proceed to question **13** | ☐ No<br>**STOP**<br>Coverage not approved |
| **13. Does the patient have documented improvement in signs of dry eye disease?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>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]