US Family Health Plan

Prior Authorization Request Form for

latanoprostene bunod ophthalmic solution (Vyzulta)

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 **617-562-5296**

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**

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. Does the patient have a diagnosis of open angle glaucoma OR ocular hypertension?	☐ Yes Proceed to question 2	☐ No **STOP** **Coverage not approved**
2. Is the patient GREATER THAN or EQUAL TO 16 years of age?	☐ Yes Proceed to question 3	☐ No **STOP** **Coverage not approved**
3. Has the patient tried and failed at least two ophthalmic prostaglandin glaucoma agents (e.g., latanoprost, bimatoprost etc.)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[16 May 2018]