US Family Health Plan
Prior Authorization Request Form for
Ophthalmic Anti-Inflammatory Immunomodulatory Agents:
Lifitegrast Ophthalmic Solution **(Xiidra)**

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**

Prior authorization for initial therapy and renewal therapy will approve for 1 time only. Continuous therapy within 120 days will not require an additional prior authorization, however, if drug therapy (patient has not filled the Rx) has a break of greater than 120 days then an additional prior authorization is required.

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 Proceed to question 2	☐ No **STOP** **Coverage not approved**
2. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question 3	☐ No **STOP** **Coverage not approved**
3. Will Xiidra be used in combination with Restasis?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question 4
4. Is Xiidra being prescribed for LASIK associated dry eyes?	☐ Yes **STOP** **Coverage not approved**	☐ No Proceed to question 5
5. Is the request for renewal of therapy?	☐ Yes Proceed to question 11	☐ No Proceed to question 6
6. Does the patient have a diagnosis of Moderate to Severe Dry Eye Disease?	☐ Yes Proceed to question 7	☐ No **STOP** **Coverage not approved**
7. Has the patient had positive symptomology screening for moderate to severe dry eye disease from an appropriate measure?	☐ Yes Proceed to question 8	☐ No **STOP** **Coverage not approved**

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8. Has the patient had at least one positive diagnostic test (e.g. Tear Film Breakup Time, Osmolarity, Ocular Surface Staining, Schirmer Tear Test)?	☐ Yes Proceed to question 9	☐ No **STOP** **Coverage not approved**
9. 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 Proceed to question 10	☐ No **STOP** **Coverage not approved**
10. 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 **Sign and date below**	☐ No **STOP** **Coverage not approved**
11. Does the patient have documented improvement in ocular discomfort?	☐ Yes Proceed to question 12	☐ No **STOP** **Coverage not approved**
12. Does the patient have documented improvement in signs of dry eye disease?	☐ 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

[25 July 2018]