US Family Health Plan
Prior Authorization Request Form for cyclosporine 0.09% ophthalmic (**Cequa**), cyclosporine 0.05% ophthalmic multi dose (**Restasis Multidose**), lifitegrast 5% 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 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**

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #:		Phone #:	
Date f Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is this medication being prescribed by an ophthalmologist or optometrist?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Will the patient use any two of Restasis, Cequa, or Xiidra at the same time?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **3**
3. What is the requested medication?	☐ Cequa - Proceed to question **5** ☐ Restasis Multidose - Proceed to question **5** ☐ Xiidra - Proceed to question **4**	
4. Does the patient have a diagnosis of moderate to severe dry eye disease?	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved
5. What is the patient's diagnosis or indication?	☐ Moderate to Severe Dry Eye Disease- Proceed to question **6** ☐ Vernal keratoconjunctivitis (VKC) - **Sign and date below** ☐ Other – **STOP** – Coverage not approved	

6. Has the patient obtained positive symptomatology screening for moderate to severe dry eye disease from an appropriate measure?	☐ Yes Proceed to question **7**	☐ No **STOP** Coverage not approved
7. Has the patient obtained AT LEAST ONE positive diagnostic test (such as Tear Film Breakup Time, Osmolarity, Ocular Surface Staining, or Schirmer Tear Test)?	☐ Yes Proceed to question **8**	☐ No **STOP** Coverage not approved
8. Has the patient tried and failed AT LEAST ONE month of ONE ocular lubricant used at optimal dosing and frequency (such as carboxymethylcellulose [Refresh, Celluvisc, Thera Tears, Genteal, etc.], polyvinyl alcohol [Liquitears, Refresh Classic, etc.], or wetting agents [Systane, Lacrilube])?	☐ Yes Proceed to question **9**	☐ No **STOP** Coverage not approved
9. Has the patient tried and failed AT LEAST ONE month of a different ocular lubricant that is non-preserved at optimal dosing and frequency (such as carboxymethylcellulose or polyvinyl alcohol)?	☐ Yes Proceed to question **10**	☐ No **STOP** Coverage not approved
10. Has the patient tried and failed a 3-month trial of cyclosporine 0.05% unit dose?	☐ 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