US Family Health Plan
Prior Authorization Request Form for
loteprednol 0.25% ophthalmic suspension **(Eysuvis)**

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 expires after 6 months.

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:**

Question		
1. **The following agents are available without a prior authorization: generic loteprednol 0.5%, Lotemax SM, Lotemax FML and Inveltys. Please consider changing the prescription to one of these agents.**	☐ Acknowledged Proceed to question **2**	
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 Eysuvis.*	☐ Yes (subject to verification) Proceed to question **3**	☐ No Proceed to question **4**
3. **Has the patient experienced improvement in dry eye signs and symptoms?**	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
4. **Is the requested medication being prescribed by or in consultation with an optometrist or ophthalmologist?**	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. **Does the patient have a diagnosis of dry eye disease as evidenced by at least one diagnostic test (for example, Tear Film Break Time, Osmolarity, Ocular Surface Staining, Schirmer Tear Test)?** Note: Non-FDA approved uses are NOT approved, including allergic conjunctivitis and for post-operative use to decrease inflammation.	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. **Has the patient tried and failed or had an adverse event to a two week course of generic loteprednol 0.5%?**	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

		Yes	No
7.	**Has the patient tried and failed or had an adverse event to a two week course of at least one low-dose ophthalmic steroid formulation (for example, Lotemax SM, Inveltys, Alrex, and FML)?**	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8.	**Will the use of Eysuvis exceed 14 days per course of therapy for dry eye disease?**	☐ Yes **STOP** **Coverage not approved**	☐ No **Sign and date below**

Step 3

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

Prescriber Signature ______________________ Date __________

[21 May 2021]