US Family Health Plan

Prior Authorization Request Form for

Latanoprost 0.005% ophthalmic solution (lyuzeh)

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 does not expire**.**

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 the requested medication prescribed by an ophthalmologist or an optometrist?	☐ Yes **Proceed to question 2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have a diagnosis of ocular hypertension or open-angle glaucoma?	☐ Yes **Proceed to question 3**	☐ No **STOP** **Coverage not approved**
3. Has the patient had a trial of appropriate duration with TWO different formulary options, from any of the following glaucoma drug classes, in combination or separately and have failed to reach intraocular pressure target goals: • **prostaglandin analogs (for example, Lumigan, Travatan, Xalatan),** • **beta blockers (for example, Timoptic),** • **alpha2-adrenergic agonists (for example, Alphagan P),** • **topical carbonic anhydrase inhibitors (for example, Azopt, Trusopt, Cosopt)?**	☐ Yes **Sign and Date below**	☐ No **Proceed to question 4**
4. Is the patient currently taking latanoprost and requires a preservative-free formulation due to experiencing adverse events?	☐ Yes **Sign and Date below**	☐ No **Proceed to question 5**

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5. Is the patient on three or more different ocular medications that contain preservatives and accumulation of preservatives is a concern?	☐ 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 _____

[14 February 2024]