US Family Health Plan
Prior Authorization Request Form for
perfluorohexyloctane 100% ophthalmic (Miebo)

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.

MAIL ORDER	**If the prescription is to be filled through the USFHP Mail Order Pharmacy, check here** ☐ • The completed form may be **faxed** to **1-617-562-5296** OR • The patient may attach the completed form to the prescription and **mail** it to: **Attn: Pharmacy, 77 Warren St, Brighton, MA 02135**	RETAIL	**If the prescription is to be filled at a retail pharmacy, check here** ☐ • The provider may **call 1-877-880-7007** OR • The completed form may be **faxed** to **617-562-5296**

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 this medication being prescribed by an ophthalmologist or optometrist?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Is the patient 18 years of age or older?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Does the patient have a diagnosis of moderate to severe dry eye disease?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Has the patient obtained positive symptomatology screening for moderate to severe dry eye disease from an appropriate measure?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. 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 **6**	☐ No **STOP** Coverage not approved
6. 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 **7**	☐ No **STOP**

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7. 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 **8**	☐ No **STOP** Coverage not approved
8. Has the patient tried and failed a 3-month trial of cyclosporine 0.05% (Restasis), cyclosporine (Cequa), or lifitegrast (Xiidra)?	☐ 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

[27 September 2023]