US Family Health Plan
Prior Authorization Request Form for Cyclosporine 0.05% Ophthalmic Emulsion Unit Dose (Restasis)

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**

LASIK surgery would approve for 3 months, all other indications would be approved for lifetime.

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 being prescribed by an ophthalmologist or optometrist?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Will the requested medication be used in combination with Xiidra or Cequa?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **3**
3. Is the requested medication being prescribed for LASIK associated dry eyes?	☐ Yes Proceed to question **4**	☐ No Proceed to question **5**
4. Did the LASIK surgery occur within the last THREE Months? *Note that therapy is limited to a maximum of THREE months of therapy after the procedure.*	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved
5. For what indication is the requested medication being prescribed?	☐ Moderate to Severe Dry Eye Disease – Proceed to question **6** ☐ Graft rejection/graft versus host disease (GvHD) - **Sign and date below** ☐ Corneal transplant - **Sign and date below** ☐ Atopic keratoconjunctivitis (AKC) - **Sign and date below** ☐ Vernal keratoconjunctivitis (VKC) - **Sign and date below** ☐ Other – **STOP** Coverage not approved	
6. Has the patient had positive symptomology 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 had at least one positive diagnostic test (for example, Tear Film Breakup Time, Osmolarity, Ocular Surface Staining, Schirmer Tear Test)?	☐ Yes Proceed to question **8**	☐ No **STOP** Coverage not approved

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8. Has the patient tried and failed at least 1 month of one ocular lubricant used at optimal dosing and frequency (for example, carboxymethylcellulose [Refresh, Celluvisc, Thera Tears, Genteal, etc], polyvinyl alcohol [Liquitears, Refresh Classic, etc], or wetting agents [Systame, Lacrilube)?	☐ Yes Proceed to question **9**	☐ No **STOP** Coverage not approved
9. Has the patient tried and failed at least 1 month of a different ocular lubricant that is non-preserved at optimal dosing and frequency (for example, carboxymethylcellulose, polyvinyl alcohol, etc.)?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved
Coverage is not approved for off label uses such as, but not limited to: Pterygia, blepharitis, ocular rosacea, and contact lens intolerance.		

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[27 Sep 2023]