Prior authorization approval expires after 1 year. For renewal of therapy an initial USFHP prior authorization approval is required.

☐ ☐

☐ ☐

☐ ☐

☐ ☐

☐ ☐

☐

☐

☐ ☐

8. 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 **9**	☐ No **STOP** **Coverage not approved**
9. Has the patient had 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 [Systane, Lacrilube])?	☐ Yes Proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Was the initial trial followed by at least 1 month of a different ocular lubricant that is non-preserved at optimal dosing and frequency (for example, carboxymethylcellulose, polyvinyl alcohol)?	☐ Yes Proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Has the patient had at least 3 month trial of cyclosporine (Restasis) 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 _____