US Family Health Plan
Prior Authorization Request Form for
varenicline tartrate **(Tyrvaya)**

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

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 optometrist?	☐ Yes Proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Has the patient received this medication under the USFHP/ TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a USFHP/ TRICARE approved PA for Tyrvaya.*	☐ Yes (subject to verification) Proceed to question **3**	☐ No Proceed to question **5**
3. Does the patient have documented improvement in ocular discomfort?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient have documented improvement in signs of dry eye disease?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
5. Is the patient greater than or equal to 18 years of age?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. What is the indication or diagnosis?	☐ Dry eye disease – Proceed to question **7** ☐ Other - **STOP Coverage not approved**	
7. Has the patient had positive symptomology screening for dry eye disease from an appropriate measure?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**

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 _____