

# US Family Health Plan

## Prior Authorization Request Form for Lotilaner (Xdemyv)

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 expires in 6 months; a new PA must be submitted.**

**Step 1 Please complete patient and physician information (please print):**

Patient Name: _____ Address: _____ Sponsor ID #: _____ Date of Birth: _____	Physician Name: _____ Address: _____ Phone #: _____ Secure Fax #: _____
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**Step 2 Please complete the clinical assessment:**

1. Is the requested medication prescribed by an ophthalmologist or optometrist?	<input type="checkbox"/> Yes <b>Proceed to question 2</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
2. Does the patient have a diagnosis of Demodex blepharitis confirmed by the presence of Demodex mites on microscopic examination?  Note: Non-FDA approved uses are NOT approved, including for dry eye disease or meibomian gland dysfunction.	<input type="checkbox"/> Yes <b>Proceed to question 3</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
3. Does the patient have Demodex infestation with at least 10 eyelashes with collarettes?	<input type="checkbox"/> Yes <b>Proceed to question 4</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
4. Is the patient greater than or equal to 18 years of age?	<input type="checkbox"/> Yes <b>Proceed to question 5</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
5. Has the patient tried and failed an adequate treatment course with topical tea tree oil?	<input type="checkbox"/> Yes <b>Proceed to question 6</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved

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<b>6. Will the patient continue to practice good eyelid hygiene including eyelid wipes (for example, Ocusoft)?</b>	<input type="checkbox"/> Yes <b>Sign and date below</b>	<input type="checkbox"/> No <b>STOP</b> <b>Coverage not approved</b>
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**Step 3** I certify the above is true to the best of my knowledge. Please sign and date:

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Prescriber Signature

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Date

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[14 Feb 2024]