PRIOR AUTHORIZATION REQUEST FORM
Restasis*

DATE OF REQUEST: ____________

MEMBER INFORMATION

NAME ______________________________

ID # ______________________________

BIRTHDATE ______________

☑ PLEASE NOTE: By signing this form, you are attesting to the accuracy of the information provided, and that medical record documentation is available if requested.

PROVIDER INFORMATION

NAME ______________________________

NPI # ______________________________

ADDRESS ______________________________

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PHONE #____________FAX #____________

CONTACT NAME ______________________

PROVIDER SIGNATURE ________________

☐ **EXTENSION REQUEST**
Check all boxes under Criteria/Limitations that apply. In addition, use the additional information section below to document response to previous treatment with Restasis.

☐ **INITIAL REQUEST** Check all boxes below that apply.

1. Diagnosis

- ☐ Member has a diagnosis of Keratoconjuctivitis Sicca

2. Previous Therapies –
Chart notes document member has continued symptoms despite the simultaneous use of:

- ☐ Long acting Artificial Tears (Refresh, Endura, or Sustane)
- ☐ Lubricant therapy at bedtime

3. Criteria/Limitations
Restasis is a covered benefit when all the following criteria are met:

- ☐ Patient is not concomitantly using punctal plugs or ophthalmic anti-inflammatory agents
- ☐ Patient is not concomitantly using daily contact lenses
- ☐ Patient does not have an active ophthalmic infection (including herpes keratitis)
- ☐ Patient has not had an ocular infection, trauma, surgery, or injury in the last 6 months
- ☐ Patient is not less than 16 years of age
- ☐ Patient is not concomitantly using other medications known to exacerbate dry eyes
- ☐ Patient does not have permanent occlusion of lacrimal puncta

Initial authorization will be limited to a maximum of 6 months. Extended authorizations up to 12 months are dependent upon response and use.

If the member does not meet all the criteria listed above, provide additional information for consideration

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☑ **PLEASE NOTE:** ALL CHART NOTES/LAB REPORTS IN REFERENCE TO THIS REQUEST MUST BE RECEIVED BEFORE A REVIEW CAN BEGIN. *REQUESTS SUBMITTED WITHOUT THIS DOCUMENTATION MAY BE DENIED.*

Refer to the MVP Formulary at www.mvphealthcare.com for those drugs that require prior authorization or are subject to quantity limits or step therapy

** Use this form for members in a Rochester-based product and Medicare Part D members only*

FAX THIS REQUEST TO:

Commercial **1-800-376-6373**
(HMO, EPO/PPO, Option Child, Healthy NY, Personal Plan, CompCare, ASO)

Medicare Part D **1-800-401-0915**
(Preferred Gold, GoldAnywhere, GoldValue, USA Care)

Effective December 1, 2009