FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Restasis® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Moderate to severe keratoconjunctivitis sicca (KCS) [dry eye]
❑ Sjogren's syndrome with suppressed tear production due to ocular inflammation
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Does the patient have a trial and failure or intolerance to at least one over-the-counter (OTC) ocular lubricant used at an optimal dose and frequency for at least two weeks (e.g., artificial tears, lubricating gels/ointments, etc)? ❑ **Yes** ❑ **No**

Will the patient be using concurrent topical ophthalmic anti-inflammatory drugs (e.g., corticosteroids, nonsteroidal anti-inflammatory drugs [NSAIDs])? ❑ **Yes** ❑ **No**

Will topical ophthalmic anti-inflammatory drugs only be used concurrently for a short period (up to 8 weeks) while transitioning to monotherapy with Restasis? ❑ **Yes** ❑ **No**

Reauthorization:

Does the patient have a positive clinical response to Restasis therapy (e.g., increased tear production or improvement in dry eye symptoms)? ❑ **Yes** ❑ **No**

Will the patient be using concurrent topical ophthalmic anti-inflammatory drugs (e.g., corticosteroids, nonsteroidal anti-inflammatory drugs [NSAIDs])? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

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Please note: This request may be denied unless all required information is received.