



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:
<input type="checkbox"/> Check if generic substitution is acceptable <input type="checkbox"/> Check if request is for continuation of therapy		Directions for Use:

Clinical Information (required)
<p>Select the diagnosis below:</p> <input type="checkbox"/> Moderate to severe keratoconjunctivitis sicca (KCS) [dry eye] <input type="checkbox"/> Sjogren's syndrome with suppressed tear production due to ocular inflammation <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____
<p>Clinical information:</p> <p>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)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Will the patient be using concurrent topical ophthalmic anti-inflammatory drugs (e.g., corticosteroids, nonsteroidal anti-inflammatory drugs [NSAIDs])? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Will topical ophthalmic anti-inflammatory drugs only be used concurrently for a short period (up to 8 weeks) while transitioning to monotherapy with Restasis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Reauthorization:</p> <p>Does the patient have a positive clinical response to Restasis therapy (e.g., increased tear production or improvement in dry eye symptoms)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Will the patient be using concurrent topical ophthalmic anti-inflammatory drugs (e.g., corticosteroids, nonsteroidal anti-inflammatory drugs [NSAIDs])? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

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

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

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