Reset Form Print Form

Prior Authorization Form

Ophthalmics – Dry Eye Agents: Restasis® and Xiidra®

Fax this form to: 1-800-424-3260

A fax cover sheet is not required.

Instructions: Please fill out all applicable sections on all pages completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the prior authorization). **Information contained in this form is Protected Health Information under HIPAA**.

☐ **NON-URGENT** ☐ **EXIGENT CIRCUMSTANCES**

MEMBER INFORMATION

Member's Last Name:

Member's First Name:

Member's Identification Number:

Date of Birth: ___ – ___ – ____

PRESCRIBER INFORMATION

Prescriber's Last Name:

Prescriber's First Name:

National Provider Identifier (NPI) Number:

DEA Number:

Office Phone Number: ___ – ___ – ____

Office Fax Number: ___ – ___ – ____

CLINICAL CRITERIA

1. What medication is being requested?

   _____

2. What is the prescriber's specialty?

   _____

3. What is the member's diagnosis for this medication?

   ☐ Sjogren's disease
   ☐ Moderate to severe keratoconjunctivitis sicca (KCS)
   ☐ Chronic dry eye disease (DED) due to KCS
   ☐ Severe atopic keratoconjunctivitis
   ☐ Chronic dry eye disease (DED) not associated with seasonal allergies
   ☐ Chronic dry eye disease (DED) secondary to Sjorgren's disease
   ☐ Other: _____

(Form continued on next page.)

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

4. Does the member have conjunctival redness?
   ☐ Yes ☐ No
5. Does the member have any of the following? (Check all that apply.)
   ☐ Corneal fluorescein staining score of > 2 points in any field on a 0 to 4 point scale
   ☐ Schirmer test (STT) of 1 to 10 mm in 5 minutes
   ☐ Tear break up time (TBUT) positive for dry eye
6. Has the member failed a trial of lubricating artificial tears administered at least 4 times per day?
   ☐ Yes ☐ No
   Provide details:

   _____
7. Has the member failed a trial of punctal plugs?
   ☐ Yes ☐ No
8. Has the member tried and failed at least two ophthalmic steroids?
   ☐ Yes ☐ No
   Provide details:

   _____
9. Does the member have a contraindication or intolerance to ophthalmic steroids?
   ☐ Yes ☐ No
   Provide details:

   _____
10. Has the member tried and failed or have a contraindication or intolerance to both Restasis® and Xiidra®?
    ☐ Yes ☐ No
    Provide details:

    _____

(Form continued on next page.)

 MHID: MRXCOM10_01

Member's Last Name: | | | | | | | | | | | | |

Member's First Name: | | | | | | | | | | | | |

For Renewals (Must also complete the sections above.):

1. Has the member attested to using the medication without a break in therapy?
   ☐ Yes ☐ No
2. Has there been an improvement in signs of DED as measured by any of the following? (Check all that apply.)
   ☐ Decrease in corneal fluorescein staining score
   ☐ Increase in number of mm per 5 minutes using Schirmer tear test
   ☐ Improvement in tear break up time (TBUT)
3. Has there been a decrease in conjunctival redness?
   ☐ Yes ☐ No
4. Has there been a decrease in ocular discomfort?
   ☐ Yes ☐ No
5. Has the member had positive clinical response to the medication?
   ☐ Yes ☐ No

_____ _____

Prescriber Signature (Required) ***Date***

(By signature, the Physician confirms the above information is accurate and verifiable by patient records.)

Fax this form to: 1-800-424-3260

Mail requests to:
Magellan Rx Management Prior Authorization Program
c/o Magellan Health, Inc.
4801 E. Washington Street
Phoenix, AZ 85034
Phone: 1-800-424-3312

