

DRY EYE DISEASE PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today's Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis:	
<input type="checkbox"/> Dry eye disease (i.e., dry eye syndrome, keratoconjunctivitis sicca [e.g., Sjögren's Syndrome]) <input type="checkbox"/> Other; please include ICD code plus description: _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. Is the patient currently treated with the requested agent? Yes No
2. Does the patient have any FDA labeled contraindications to the requested agent? Yes No
 If yes, please specify FDA labeled contraindications: _____
3. Will the patient be using the requested agent in combination with Verkazia (cyclosporine) or another target agent in this program (e.g., Cequa, Eysuvis, Miebo, Restasis, Tyrvaya, Vevye, Xiidra)? Yes No
4. Is the prescriber a specialist or has consulted with a specialist related to the requested diagnosis (e.g., ophthalmologist, optometrist, rheumatologist)? Yes No
5. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____

For dry eye disease requests, please submit chart notes to support the answers to the following questions:

6. Has the patient previously tried or is currently using aqueous enhancements (e.g., artificial tears, gels, ointments [target agents not included])? Yes No
7. Does the patient have an intolerance or hypersensitivity to aqueous enhancements? Yes No
8. Does the patient have an FDA labeled contraindication to ALL aqueous enhancements? Yes No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
For renewal requests: 9. Has the patient had clinical benefit with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please fax or mail this form to: Prime Therapeutics LLC Clinical Review Department 2900 Ames Crossing Road Suite 200 Eagan, MN 55121 TOLL FREE		CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.	
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