

**VERKAZIA  
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](http://www.myprime.com). Start saving time today by filling out this form electronically. Visit [covermymeds.com](http://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"/> Vernal keratoconjunctivitis (VKC) <input type="checkbox"/> Other (ICD code, plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

**For all requests:**

1. Is the patient currently being 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 Cequa, Restasis, Vevye, or Xiidra? .....  Yes  No
4. 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 vernal keratoconjunctivitis (VKC) requests:**

5. Has the patient tried and had an inadequate response to combination of a topical ophthalmic mast cell stabilizer AND an antihistamine used in the treatment of VKC? .....  Yes  No  
If no, does the patient have an intolerance or hypersensitivity to combination of a topical ophthalmic mast cell stabilizer AND an antihistamine used in the treatment of VKC? .....  Yes  No  
If yes, please explain intolerance/hypersensitivity: \_\_\_\_\_  
\_\_\_\_\_
- If no, does the patient have an FDA labeled contraindication to ALL topical ophthalmic mast cell stabilizers AND antihistamines? .....  Yes  No  
If yes, please specify FDA labeled contraindication: \_\_\_\_\_  
\_\_\_\_\_

**Please continue to the next page.**

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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**For renewal requests:**

6. Has the patient had clinical benefit with the requested agent? .....  Yes  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**

**Phone:** **Fax: 877.243.6930**  
**BCBSIL: 800.285.9426**  
**BCBSMT: 888.723.7443**  
**BCBSNM: 800.544.1378**  
**BCBSOK: 800.991.5643**  
**BCBSTX: 800.289.1525**

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