TRICARE Prior Authorization Request Form for
cyclosporine 0.09% (**Cequa**), cyclosporine 0.05% multi dose (**Restasis Multidose**),
cyclosporine 0.1% (**Vevye**), lifitegrast 5% (**Xiidra**) ophthalmic solution

JOHNS HOPKINS
HEALTH PLANS
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Prior authorization does not expire.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date f Birth: Secure Fax #: _____

Step 2 **Please complete the clinical assessment:**

1. Is this medication being prescribed by an ophthalmologist or optometrist?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Will the patient use any two of Restasis, Cequa, Vevye, or Xiidra at the same time?	☐ Yes **STOP** Coverage not approved	☐ No Proceed to question **3**
3. What is the requested medication?	☐ Cequa - Proceed to question **6** ☐ Restasis Multidose - Proceed to question **6** ☐ Vevye - Proceed to question **4** ☐ Xiidra - Proceed to question **5**	
4. Is the patient 18 years of age or older?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Does the patient have a diagnosis of moderate to severe dry eye disease?	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved
6. What is the patient's diagnosis or indication?	☐ Moderate to Severe Dry Eye Disease- Proceed to question **7** ☐ Vernal keratoconjunctivitis (VKC) - **Sign and date below** ☐ Other – **STOP** – Coverage not approved	

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7. Has the patient obtained positive symptomatology screening for moderate to severe dry eye disease from an appropriate measure?	☐ Yes Proceed to question **8**	☐ No **STOP** Coverage not approved
8. Has the patient obtained AT LEAST ONE positive diagnostic test (such as Tear Film Breakup Time, Osmolarity, Ocular Surface Staining, or Schirmer Tear Test)?	☐ Yes Proceed to question **9**	☐ No **STOP** Coverage not approved
9. Has the patient tried and failed AT LEAST ONE month of ONE ocular lubricant used at optimal dosing and frequency (such as carboxymethylcellulose [Refresh, Celluvisc, Thera Tears, Genteal, etc.], polyvinyl alcohol [Liquitears, Refresh Classic, etc.], or wetting agents [Systane, Lacrilube])?	☐ Yes Proceed to question **10**	☐ No **STOP** Coverage not approved
10. Has the patient tried and failed AT LEAST ONE month of a different ocular lubricant that is non-preserved at optimal dosing and frequency (such as carboxymethylcellulose or polyvinyl alcohol)?	☐ Yes Proceed to question **11**	☐ No **STOP** Coverage not approved
11. What is the requested medication?	☐ Cequa - Proceed to question **12** ☐ Restasis Multidose - Proceed to question **12** ☐ Vevye - Proceed to question **13** ☐ Xiidra - Proceed to question **12**	
12. Has the patient tried and failed a 3-month trial of cyclosporine 0.05% unit dose?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved
13. Has the patient had at least a 3 month trial of cyclosporine (Restasis) cyclosporine 0.09% (Cequa) AND lifitegrast (Xiidra)?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____

Prescriber Signature Date

[14 Aug 2024]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: