SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Dry Eye Medications

Drug Requested: (select one from below)

❑ **Cequa®** (cyclosporine ophthalmic solution) **0.09%**	❑ **Lacrisert®** (hydroxypropyl cellulose ophthalmic insert)
❑ **Miebo™** (perfluorohexyloctane ophthalmic solution)	❑ **Restasis MultiDose®** (cyclosporine ophthalmic emulsion) **0.05%**
❑ **Tryptyr®** (acoltremon ophthalmic solution) **0.003%**	❑ **Tyrvaya®** (varenicline solution) **nasal spray 0.03 mg**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Quantity Limits:

- **Cequa®** and **Lacrisert®:** 60-unit doses or single-use vials per 30 days
- **Miebo™:** 1 bottle (3 mL) per 30 days
- **Restasis MultiDose®:** 1 bottle (5.5 mL) per 30 days
- **Tyrvaya®:** 2 bottles (1 package of 8.4 mL) per 30 days
- **Tryptyr®:** 60 single-dose vials per 30 days

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member has tried and failed **at least 30 days** of therapy with **BOTH** of the following medications:
  - ❑ generic cyclosporine 0.05% ophthalmic emulsion
  - ❑ Xiidra® (lifitegrast ophthalmic solution) 5%

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: ~~9/21/2023;~~ 9/25/2025
REVISED/UPDATED/REFORMATTED: ~~11/6/2023; 4/16/2025;~~ **10/22/2025**