SENTARA COMMUNITY PLAN
(MEDICAID)

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.**

Ophthalmic Immunomodulator Drugs

Drug Requested: (Check below the drug that applies)

PREFERRED (must be tried and failed FIRST)	
❑ **Restasis®** (cyclosporine)	❑ **Xiidra®**
Non-Preferred	
❑ **Cequa™** (cyclosporine)	❑ **Eysuvis®** (loteprednol)
❑ **cyclosporine**	❑ **Miebo™**
❑ **Restasis Multidose®** (cyclosporine)	❑ **Tryptyr®**
❑ **Tyrvaya™** (varenicline tartrate) **Nasal Spray**	❑ **Verkazia®** (cyclosporine) *Trial and failure of preferred agents do not apply

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 Name/Form/Strength: _____

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

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

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

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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.

❑ **Cequa™** (cyclosporine)**, cyclosporine, Miebo™, Restasis Multidose®** (cyclosporine)**, Tryptyr®** (acoltremon), **Tyrvaya™** (varenicline tartrate) **Nasal Spray**

❑ Member has a trial and failure of **TWO (2)** preferred alternatives: **(Check all that apply)**

❑ Restasis® (cyclosporine)	❑ Xiidra®

❑ **Eysuvis®** (loteprednol)
Quantity Limit: 1 bottle per 3 months

❑ Member has a diagnosis of dry eye disease

AND

❑ Prescriber attest to utilizing Eysuvis® for short-term treatment (up to 2 weeks of therapy)

AND

❑ Member has a trial and failure of **TWO (2)** preferred alternatives:

❑ Restasis® (cyclosporine)	❑ Xiidra®

❑ **Verkazia®** (cyclosporine) **(Routine PDL criteria does not apply)**
Quantity Limit: 120 single-dose vials per 30 days 1 bottle per 3 months.

❑ Member is at least 4 years of age

❑ The provider is an ophthalmologist or an optometrist in consultation with an ophthalmologist

❑ Member has a diagnosis of severe vernal keratoconjunctivitis

❑ Member has trial and failure, contraindication or intolerance to at least **one** of the following:

- ❑ Topical ophthalmic "dual action" mast cell stabilizer and antihistamine (e.g., olopatadine, azelastine)
- ❑ Topical ophthalmic mast cell stabilizers (e.g., cromolyn)

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MEDICAL NECESSITY: Provide clinical evidence that the **PREFERRED** drugs will not provide adequate benefit.

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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.*

REVISED/UPDATED/REFORMATTED: ~~1/5/2022; 7/15/2022; 7/12/2023; 9/26/2023; 12/20/2023; 6/20/2025,~~ **9/10/2025**