

OPTIMA HEALTH PLAN

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 information provided is not complete, correct, or legible, authorization may be delayed.**

Dry Eye Medications

Drug Requested: (select one from below)

<input type="checkbox"/> Cequa™ (cyclosporine ophthalmic solution) 0.09%	<input type="checkbox"/> Lacrisert® (hydroxypropyl cellulose ophthalmic insert)
<input type="checkbox"/> Miebo™ (perfluorohexyloctane ophthalmic solution)	<input type="checkbox"/> Tyrvaya® (varenicline solution nasal spray) 0.03 mg

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

Member Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code: _____

Weight: _____ Date: _____

Quantity Limits:

- **Cequa™** and **Lacrisert®**: 60-unit doses or single-use vials per 30 days
- **Miebo™**: 1 bottle (5 mL) per 30 days
- **Tyrvaya™**: 2 bottles (1 package of 8.4 mL) 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:
 - ☐ Brand Restasis®
 - ☐ 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.