

OPHTHALMIC IMMUNOMODULATORS PRIOR AUTHORIZATION FORM

- Please submit **all** requested documentation with this form. Incomplete documentation may delay the processing of this request.
- Prior authorization guidelines for **Ophthalmic Immunomodulators** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	total # pages: _____	
Name of office contact:		Prescriber name:	
Contact's phone number:		Specialty:	
LTC facility contact/phone:		State license #:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:	<input type="checkbox"/> Restasis Multidose <input type="checkbox"/> Xiidra 5% droperette <input type="checkbox"/> _____		
Dose/directions:	Quantity:	Refills:	
Diagnosis (<i>submit documentation</i>):	Dx code (<i>required</i>):		
1. Has the beneficiary tried and failed the preferred Ophthalmic Immunomodulator, Restasis 0.05% droperette ?	<input type="checkbox"/> Yes – <i>Submit all supporting documentation of drug regimen tried and treatment outcomes.</i> <input type="checkbox"/> No		
2. Does the beneficiary have any contraindications or intolerances to the preferred Ophthalmic Immunomodulator, Restasis 0.05% droperette ?	<input type="checkbox"/> Yes – <i>Submit all supporting documentation of intolerances and contraindications.</i> <input type="checkbox"/> No		

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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