PRO ACT
PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Restasis® Prior Authorization Request Form (Page 1 of 2)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Corneal inflammatory condition for which the patient has required extemporaneously compounded cyclosporine ophthalmic preparations
❑ Dry eye disease (DED)
❑ Moderate to severe keratoconjunctivitis sicca (KCS) [dry eye]
❑ Sjogren's syndrome with suppressed tear production due to ocular inflammation
❑ Other diagnosis:_____ICD-10 Code(s): _____

Clinical information:

Does the patient have suppressed tear production due to ocular inflammation as determined by one of the following diagnostic tests listed below? ❑ **Yes** ❑ **No**

- Schirmer test (aqueous tear production and clearance)
- Tear break-up time
- Ocular surface dye staining
- Tear film osmolarity
- Fluorescein clearance test/tear function test

Does the patient have failure or intolerance to at least one over-the-counter (OTC) ocular lubricant used at an optimal dose and frequency for at least two weeks (e.g., artificial tears, lubricating gels/ointments, etc)? ❑ **Yes** ❑ **No**

Will the patient be using concurrent topical ophthalmic anti-inflammatory drugs (e.g., corticosteroids, NSAIDS)? ❑ **Yes** ❑ **No**

Will topical ophthalmic anti-inflammatory drugs only be used concurrently for a short period (up to 8 weeks) while transitioning to monotherapy with Restasis? ❑ **Yes** ❑ **No**

Reauthorization:

Does the patient have a positive clinical response to Restasis therapy (e.g., increased tear production or improvement in dry eye symptoms)? ❑ **Yes** ❑ **No**

Will the patient be using concurrent topical ophthalmic anti-inflammatory drugs (e.g., corticosteroids, NSAIDS)? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

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I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	