

Prior Authorization Checklist:

Chronic Dry Eye Medications

For Patient Security, please print and fax form to:

**855-891-1169**

# History of Dry Eye (Select all that apply)

|  |  |  |
| --- | --- | --- |
| Initial Onset of Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Burning | Tearing | Contact Lens Intolerance |
| Eye Pain | Photosensitivity | Blurry Vision |
| Sensation of Foreign Body | Redness | Other: |
| Dryness | Itching |  |

# Diagnosis

|  |  |
| --- | --- |
| H16.223 Keratoconjunctivities sicca, not specified as Sjogren’s, bilateral | Other ICD-10 Code:  Description: |

# Testing Completed (Select all that apply. Include measurements)

|  |  |  |  |
| --- | --- | --- | --- |
| Test | Measurement | Test | Measurement |
| Fluorescein clearance test/tear function index |  | Ocular surface dye staining using Fluorescein, rose Bengal or lissamie green dye |  |
| Tear Break up time |  | Schirmer Test |  |
| MMP-9 Elevated concentration in tears |  | Tear Osmolarity |  |

Treatment History (Most payer policies require a lack of response to at least 2 over the counter agents or treatments.)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Drug/Product Type | Drug/Product Name | Dose | Frequency of Use | Outcome | Start Date | End Date |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| Some payors may also require a copy of the patient’s medical records, including chart notes, to support previous failures. We will contact your office if these documents are needed. | | | | | | |

# Continuation of Therapy

|  |  |  |  |
| --- | --- | --- | --- |
| Drug/Product Name | Dose | Frequency of Use | Outcome |
|  |  |  |  |
|  |  |  |  |

# Patient Info

|  |  |  |
| --- | --- | --- |
| Patient Name | Date of Birth | Allergies |
| Home Phone | Mobile Number |
| Address, City, State, Zip Code | | |

# Provider Information

|  |  |
| --- | --- |
| Provider Name | Provider Phone |
| Contact Person | Contact Email |
| NPI | |

# Prescription (Send eScript or Fill, Print and Sign Below)

**Xiidra 5%**

**Restasis .05%** *Date* (click here) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I give my permission to interchange between Xiidra/Restasis depending on which is covered by patient insurance

Signature

**Directions:** Apply 1 drop o.u. b.i.d.

**Quantity (Months):**  1  3 **Refills:**  3  6  PRN