



Restasis® (cyclosporine ophthalmic emulsion 0.05%) Prior Authorization Request Form

Please fax the completed request form to the Coventry Health Care Pharmacy Department at 877-815-8751. For additional information please call 800-647-2240.

Patient Name: _____ Today's Date: ____/____/____
 Patient Pharmacy ID: _____ Date of Birth: ____/____/____
(located on bottom right of insurance card)
 Requesting Physician: _____ Specialty: _____
(Please print)
 Office Contact Person: _____ Phone #: (____)____-____ ext ____
 Office Address: _____
 Medication/dose Requested: _____ Fax #: ____ (____) ____ - ____
 Expected Duration of Therapy: _____ ICD-9 _____

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|------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 1. Is the patient 16 years of age or older? | YES | NO |
| 2. Does the patient have a diagnosis of keratoconjunctivitis sicca (dry eyes)? | YES | NO |
| 3. Has the patient tried and failed two or more traditional therapy for dry eyes (e.g., artificial tears, ocular lubricants, tear inserts)? List: _____ | YES | NO |
| 4. Is the patient currently using topical anti-inflammatory drugs (e.g., topical ophthalmic corticosteroids)? List: _____ | YES | NO |
| 5. Is the patient currently using punctual plugs? | YES | NO |
| 6. Does the patient have an active ocular infection? | YES | NO |

Physician's Signature: _____ Date: ____/____/____

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| For Mercy Health Plans use only: | Date Reviewed: ____/____/____ |
| <input type="checkbox"/> Approved Length of Approval _____ | |
| <input type="checkbox"/> Denied Reason for Denial _____ | |
| Reviewer's Signature: _____ | |
| Override entered in <input type="checkbox"/> Caremark <input type="checkbox"/> CCMS for _____ to _____ by: _____ | |
| Office notified on _____; at _____ am/pm; by _____ spoke to _____ | |