Updated: xx/xx
DMMA Approved: xx/xx

Request for Prior Authorization for Drug Name
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Rhopressa (netarsudil ophthalmic solution require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Rhopressa (netarsudil ophthalmic solution) Authorization Criteria:

Disclaimer: All requests for Rhopressa (netarsudil ophthalmic solution) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Coverage may be provided with a diagnosis of open-angle glaucoma or ocular hypertension and the following criteria is met:

- Member is an adult 18 years of age or older
- Prescribed by, or in consultation with optometrist or ophthalmologist
- Must provide documentation showing the member has tried and failed (which will be verified via pharmacy claims if available) or had an intolerance or contraindication to latanoprost and timolol
- Baseline IOP
    - IOP must be less than 30mmHg
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 6 months
- **Reauthorization criteria**
    - Current IOP (within 6 months) that decreased or has remained stable
- **Reauthorization Duration of approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

HIGHMARK. Delaware HEALTH OPTIONS

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Rhopressa (netarsudil ophthalmic solution)
PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (844) 325-6253 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Health Options ID:	

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Frequency:	Duration:	
Is the member currently receiving requested medication? ☐ Yes ☐ No		Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Most recent IOP and the date recorded:

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Most recent IOP and the date recorded:

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No
Please describe:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date