Updated: 05/2019
DMMA Approved: 05/2019

Request for Prior Authorization for Ocular Rho Kinase Inhibitors
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Ocular Rho Kinase Inhibitors require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Ocular Rho Kinase Inhibitors Prior Authorization Criteria:

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
- For Rhopressa (Netarsudil):
    - Provider attestation that baseline IOP is less than 30mmHg
- For Rocklatan (Netarsudil/ Latanoprost):
    - Provider attestation that baseline IOP is less than 36mmHg
- 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**
    - Provider attestation that current IOP (within 6 months) has decreased or 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.

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OCULAR RHO KINASE INHIBITORS (Rhopressa and Rocklatan) 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:	Member weight: _____pounds or _____kg

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: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: ICD-10 _____
For Rhopressa:
Was recorded intraocular pressure less than 30mmHg? ☐ Yes ☐ No
For Rocklatan:
Was recorded intraocular pressure less than 36mmHg? ☐ Yes ☐ No

CURRENT or PREVIOUS THERAPY

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

REAUTHORIZATION

Has the member had a recent (within 6 months) that show an IOP that decreased or remained stable with treatment?
☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date