Updated: 06/2019
PARP Approved: 06/2019

Prior Authorization Criteria

# Ocular Rho Kinase inhibitors

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.

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 an 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 (within 6 months) IOP 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.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Gateway Health

Updated: 06/2019
PARP Approved: 06/2019

# Ocular Rho Kinase inhibitors
# PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
**PHONE**: (800) 392-1147 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: |
| Gateway 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: |

## 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 |
|---|---|
| | |