Updated: 03/2023
DMMA Approved: 03/2023

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

All requests for Restasis (cyclosporine ophthalmic emulsion) require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

**Restasis Prior Authorization Criteria:**

Members with historical pharmacy claims data meeting the following criteria will receive automatic authorization at the pharmacy point of service without the requirement for documentation of additional information. If pharmacy claims data cannot obtain the criteria below, documentation will be required to indicate the member meets the criteria. Claims will automatically adjudicate on-line, without a requirement to submit for prior authorization when the following criteria is met:

- Member is 16 years of age or older.
- Member must have a history of trial and failure, contraindication, or intolerance to at least one 30-d trial using ocular lubricants/artificial tears within the past 90 days.
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
    - Members with historical pharmacy claims data meeting the following criteria will receive automatic reauthorization at the pharmacy point of service without the requirement for documentation of additional information. If pharmacy claims data cannot obtain the criteria below, documentation will be required to indicate the member meets the reauthorization criteria below. Claims will automatically adjudicate on-line, without a requirement to submit for reauthorization when the following criteria is met:
        - Documentation the member has been on Restasis (cyclosporine ophthalmic emulsion) within the last 180 days

**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.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

HIGHMARK HEALTH OPTIONS

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# RESTASIS (CYCLOSPORINE OPHTHALMIC EMULSION) 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) 325-6251 Monday through Friday 8:00am to 7:00pm

## PROVIDER INFORMATION

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

## MEMBER INFORMATION

| | |
|---|---|
| Member Name: | DOB: |
| Member ID: | Member weight: _____pounds or _____kg |

## REQUESTED DRUG INFORMATION

| | | |
|---|---|---|
| Medication: | Strength: | |
| Directions: | Quantity: | Refills: |
| 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: |
| | |
| | |

Has the member tried and failed for at least 30 days, has a contraindication, or intolerance to an ocular lubricant/artificial tears within the past 90 days? ☐ Yes ☐ No

## CURRENT or PREVIOUS THERAPY

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

## SUPPORTING INFORMATION or CLINICAL RATIONALE

| |
|---|
| |
| |
| |

| Prescribing Provider Signature | Date |
|---|---|
| | |