

AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-305-671-0200.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Dry Eye Medications

Drug Requested: (select one from below)

☐ Cequa [®] (cyclosporine ophthalmic solution) 0.09%	☐ Lacrisert [®] (hydroxypropyl cellulose ophthalmic insert)
☐ Miebo [™] (perfluorohexyloctane ophthalmic solution)	☐ Restasis MultiDose [®] (cyclosporine ophthalmic emulsion) 0.05%
☐ Tryptyr [®] (acotremone ophthalmic solution) 0.003%	☐ Tyrvaya [®] (varenicline solution) nasal spray 0.03 mg

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

Quantity Limits:

- **Cequa**[®] and **Lacrisert**[®]: 60-unit doses or single-use vials per 30 days
- **Miebo**[™]: 1 bottle (3 mL) per 30 days
- **Restasis MultiDose**[®]: 1 bottle (5.5 mL) per 30 days
- **Tyrvaya**[®]: 2 bottles (1 package of 8.4 mL) per 30 days
- **Tryptyr**[®]: 60 single-dose vials per 30 days

(Continued on next page)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ☐ Member has tried and failed **at least 30 days** of therapy with **BOTH** of the following medications:
 - ☐ generic cyclosporine 0.05% ophthalmic emulsion
 - ☐ Xiidra® (lifitegrast ophthalmic solution) 5%

Not all drugs may be covered under every Plan.

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.