

## Ophthalmic Immunomodulators (Xiidra) - Washington Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.

**This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.  
Allow at least 24 hours for review.**

### Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____		

### Section B - Provider Information

First Name:	Last Name:	M.D./D.O.
Address:	City:	State: ZIP code:
Phone:	Fax:	NPI #: Specialty:
Office Contact Name / Fax attention to:		

### Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

### Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

### Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at [www.uhcprovider.com](http://www.uhcprovider.com) for a list of preferred alternatives

## Ophthalmic Immunomodulators (Xiidra) - Washington Prior Authorization Request Form

Member First name:	Member Last name:	Member DOB:
--------------------	-------------------	-------------

### Clinical and Drug Specific Information

#### ALL REQUESTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a diagnosis of moderate to severe chronic dry eye disease (DED)?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is there documentation provided indicating an abnormal result or response to one or more of the following dry eye disease diagnostic/assessment methods?</b> <input type="checkbox"/> Tear break-up time (less than 10 seconds) <input type="checkbox"/> Ocular surface dye staining using fluorescein, rose bengal, or lissamine green dyes <input type="checkbox"/> Schirmer test (aqueous tear production of less than or equal to 10 mm of strip wetting in 5 minutes) <input type="checkbox"/> Fluorescein clearance test/tear function index <input type="checkbox"/> Tear osmolarity (indicating tear film instability) <input type="checkbox"/> Tear lactoferrin concentrations in the lacrimal gland (decreased)
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a history of failure, contraindication or clinically significant intolerance to cyclosporine 0.05% ophthalmic emulsion (RESTASIS) for at least 28 days?</b> <i>(If yes, complete Section D above)</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the medication being used concomitantly with cyclosporine 0.05% ophthalmic emulsion (Restasis)?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Dose the dose exceed 2 drops per day in each eye?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the medication prescribed by or in consultation with a specialist in eye care or rheumatology?</b>
<b>CONTINUATION OF THERAPY</b>	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is there documentation of clinically significant improvement?</b> <i>If yes, list improvement:</i>

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Confidentiality Notice:** This transmission contains confidential information belonging to the sender and UnitedHealthcare. This information is intended only for the use of UnitedHealthcare. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action involving the contents of this document is prohibited. If you have received this telecopy in error, please notify the sender immediately.