



**Restasis® (cyclosporine ophthalmic emulsion 0.05%) Prior Authorization Request Form**

Please fax the completed request form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 800-466-9854. For additional information please call 314-214-8282 or 800-647-2240.

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_
Patient Pharmacy ID: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_
(located on bottom right of insurance card)
Requesting Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_
(Please print)
Office Contact Person: \_\_\_\_\_ Phone #: (\_\_\_\_)\_\_\_\_ - \_\_\_\_ ext \_\_\_\_
Office Address: \_\_\_\_\_
Medication/dose Requested: \_\_\_\_\_ Fax #: \_\_\_\_ (\_\_\_\_) \_\_\_\_ - \_\_\_\_
Expected Duration of Therapy: \_\_\_\_\_ ICD-9 \_\_\_\_\_

1. Is the patient 16 years of age or older? YES NO
2. Does the patient have a diagnosis of keratoconjunctivitis sicca (dry eyes)? YES NO
3. Has the patient tried and failed traditional therapy for dry eyes (e.g., artificial tears, ocular lubricants, tear inserts)? List: \_\_\_\_\_ YES NO
4. Has the patient tried and failed the product Refresh Endura? YES NO
5. Is the patient currently using topical anti-inflammatory drugs (e.g., topical ophthalmic corticosteroids)? List: \_\_\_\_\_ YES NO
6. Is the patient currently using punctual plugs? YES NO
7. Does the patient have an active ocular infection? YES NO

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

For Mercy Health Plans use only: Date Reviewed: \_\_\_\_/\_\_\_\_/\_\_\_\_
Approved Length of Approval \_\_\_\_\_
Denied Reason for Denial \_\_\_\_\_
Reviewer's Signature: \_\_\_\_\_
Override entered in Caremark CCMS for \_\_\_\_\_ to \_\_\_\_\_ by: \_\_\_\_\_
Office notified on \_\_\_\_\_; at \_\_\_\_\_ am/pm; by \_\_\_\_\_ spoke to \_\_\_\_\_