Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS (MEDICAID)

Restasis-Xiidra (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-855-684-5250**.
When conditions are met, we will authorize the coverage of Restasis-Xiidra (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Restasis (cyclosporine ophthalmic emulsion 0.05%) Xiidra (lifitegrast ophthalmic solution 5%)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Has Aetna Better Health authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, then skip to question 3.]

2. Has the patient had a response to treatment? Y N

   [No further questions.]

3. Is the requested drug prescribed by, or in consultation with, an ophthalmologist or optometrist? Y N

   [If no, then no further questions.]

4. Does the patient have a diagnosis of Keratoconjunctivitis Sicca (KCS-dry eyes), Dry Eye Disease, or Dry Eyes due to Sjogren's syndrome? Y N

   [If no, then no further questions.]

5. Has the patient experienced an inadequate treatment response or intolerance to at least 2 different forms (i.e., gels, ointments, or liquids) of formulary artificial tears used at least 4 times a day? Y N

   [If no, then no further questions.]

6. Is this request for Restasis for a patient 16 years of age or older? Y N

   [If yes, then no further questions.]

7. Is this request for Xiidra for a patient 17 years of age or older? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date