UnitedHealthcare Community Plan

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: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ 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? □ Yes □ 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 for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

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

Provider Signature: _____ **Date:** _____