CAREFIRST MD
Miebo PA with Limit 6007-C

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 855-582-2038 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Miebo PA with Limit 6007-C.

Patient Information

Patient Name:
Patient Phone: ☐☐☐-☐☐☐-☐☐☐☐
Patient ID:
Patient Group:
Patient DOB: ☐☐/☐☐/☐☐☐☐

Physician Information

Physician Name
Physician Phone: ☐☐☐-☐☐☐-☐☐☐☐
Physician Fax: ☐☐☐-☐☐☐-☐☐☐☐
Physician Addr.:
City, St, Zip:

Drug Name (select from list of drugs shown)

Miebo (perfluorohexyloctane ophthalmic solution)

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

_____

Please check the appropriate answer for each applicable question.

1.	Is the requested drug being prescribed for the treatment of the signs and symptoms of dry eye disease?	**Y** ☐	**N** ☐
2.	Is this request for continuation of therapy?	**Y** ☐	**N** ☐
3.	Has the patient achieved or maintained improvement in their signs and symptoms of dry eye disease from baseline (e.g., ocular irritation, redness, mucous discharge, reduced visual function, ocular surface damage, reduced tear production)?	**Y** ☐	**N** ☐
4.	Has the patient experienced an inadequate treatment response to an artificial tears product?	**Y** ☐	**N** ☐
5.	Has the patient experienced an intolerance to an artificial tears product?	**Y** ☐	**N** ☐
6.	Does the patient have a contraindication that would prohibit a trial of an artificial tears product?	**Y** ☐	**N** ☐
7.	Does the patient require more than the plan allowance of 8 drops per day of the requested drug?	**Y** ☐	**N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date

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