Prior Authorization Form

CAREFIRST

Tyrvaya PA with Limit

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Tyrvaya PA with Limit.

Drug Name (select from list of drugs shown)
Tyrvaya (varenicline)

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: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1.	Is the requested drug being prescribed for the treatment of the signs and symptoms of dry eye disease?	Y N
	[If Yes, then go to 2. If No, then no further questions.]	
2.	Is this request for continuation of therapy?	Y N
	[If Yes, then go to 3. If No, then go to 4.]	
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

	[If Yes, then go to 4. If No, then no further questions.]
4.	Does the patient require more than the plan allowance of 4 sprays per day of the requested drug? Y N
	[No further questions]

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