Prior Authorization Form

CAREFIRST

Xiidra*

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 Xiidra*.

Drug Name (select from list of drugs shown)

Xiidra (lifitegrast ophthalmic solution)

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 dry eye disease?	Y N
	[If yes, go to 2. If no, then no further questions.]	
2.	Is this request for continuation of therapy?	Y N
	[If yes, go to 3. If no, 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, go to 4. If no, then no further questions.]
4. Does the patient require more than the plan allowance of 4 drops 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