BlueCross BlueShield
Federal Employee Program

TRYPTYR
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the cardholder portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Tryptyr

(acoltremon ophthalmic solution)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

Will the patient need more than 180 single-dose vials (3 cartons) every 90 days? ❑Yes* ❑No

If YES, please specify the requested quantity: _____ single-dose vials every 90 days

1. Does the patient have a diagnosis of chronic dry eye? ❑Yes ❑No

2. Will this medication be used in combination with another legend ophthalmic medication for the treatment of dry eyes? ❑Yes* ❑No

If YES, please specify medication: _____

Legend Ophthalmic Medications: Cequa (cyclosporine), Eysuvis (loteprednol), Miebo (perfluorohexyloctane), Restasis (cyclosporine), Tyrvaya (varenicline), Tryptyr (acoltremon), Vevye (cyclosporine), Xiidra (lifitegrast)

3. Has the patient been on Tryptyr continuously for the last **6 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

a. Has the patient been evaluated by an optometrist, ophthalmologist, or a physician specializing in the treatment of the patient's condition? ❑Yes ❑No

b. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one cellulose or polyol containing artificial tears (e.g., hydroxyethyl cellulose, methylcellulose, Dextran 70, Glycerin, povidone, etc.)? ❑Yes ❑No

c. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one lipid-containing artificial tears (e.g., mineral oil, castor oil, flaxseed oil, etc.)? ❑Yes ❑No

d. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to at least one legend ophthalmic medication for the treatment of dry eyes? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:

a. Has the patient had an improvement in symptoms? ❑Yes ❑No

