Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Restasis

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 Restasis.

Drug Name (select from list of drugs shown)
Restasis (cyclosporine ophthalmic emulsion)

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
2.	Has the patient tried and failed or been intolerant to artificial tears products?	Y N
3.	Will the patient be using ophthalmic anti-inflammatory drugs concurrently with the requested drug?	Y N
	[If no, then no further questions.]	
4.	Will the ophthalmic anti-inflammatory drugs be used concurrently for a short period (2 to 4 weeks) while transitioning to monotherapy with the requested drug?	Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date