

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

RESTASIS (cyclosporine)

Patient name: _____ Medicaid ID #: _____

Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____

Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____

Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____

Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF
MEDICAL NECESSITY TO 855-828-4992 note the new fax number**

I. Approved for the following diagnoses (ICD.9):

- 370.20 Superficial keratitis, unspecified
- 370.21 Punctate keratitis
- 370.33 Keratoconjunctivitis sicca, not specified as Sjogren's disease
- 710.2 Sicca syndrome- Sjogren's disease

Documentation requirements for the above diagnoses:

1. Diagnosis
2. Documented fluorescein test.
3. Request from ophthalmologist or with documented ophthalmologist consult.

AUTHORIZATION:

Prior approval for the above diagnosis is for 1 year.

RE-AUTHORIZATION:

Additional periods require steps 1-3

II. Restasis for Post Corneal Transplant (ICD.9)

V 42.5 Post Corneal Transplant

Documentation of post corneal transplant:

Diagnosis only

AUTHORIZATION:

Prior approval is for 1 year

RE-AUTHORIZATION

Updated letter of medical necessity

INFORMATION:

Maximum supply is 1 box of 32 dropperettes/month

9/20/10

<http://health.utah.gov/medicaid/pharmacy>