



**Restasis® (cyclosporine ophthalmic emulsion 0.05%) Prior Authorization Request Form**

Please fax the completed request form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 800-466-9854. For additional information please call 314-214-8501 or 800-647-2240.

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Patient Pharmacy ID: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(located on bottom right of insurance card)  
Requesting Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_  
(Please print)  
Office Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Office Address: \_\_\_\_\_  
Medication/dose Requested: \_\_\_\_\_ Fax #: \_\_\_\_\_  
Expected Duration of Therapy: \_\_\_\_\_ ICD-9 \_\_\_\_\_

|   |     |    |
|---|-----|----|
| 1. Is the patient 16 years of age or older?   | YES | NO |
| 2. Does the patient have a diagnosis of keratoconjunctivitis sicca (dry eyes)?  | YES | NO |
| 3. Has the patient tried and failed traditional therapy for dry eyes (e.g., artificial tears, ocular lubricants, tear inserts)? List: _____ | YES | NO |
| 4. Has the patient tried and failed the product Refresh Endura?   | YES | NO |
| 5. Is the patient currently using topical anti-inflammatory drugs (e.g., topical ophthalmic corticosteroids)? List: _____                   | YES | NO |
| 6. Is the patient currently using punctual plugs?   | YES | NO |
| 7. Does the patient have an active ocular infection?  | YES | NO |

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**For Mercy Health Plans use only:** Date Reviewed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Approved Length of Approval \_\_\_\_\_

Denied Reason for Denial \_\_\_\_\_

Reviewer's Signature: \_\_\_\_\_

Override entered in  Caremark  CCMS for \_\_\_\_\_ to \_\_\_\_\_ by: \_\_\_\_\_

Office notified on \_\_\_\_\_; at \_\_\_\_\_ am/pm; by \_\_\_\_\_ spoke to \_\_\_\_\_