PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Restasis

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:

Member Number:

Date of Birth:

Group Number:

Address:

City, State, Zip:

Member Phone:

Prescriber Name:

Fax: Phone:

Office Contact:

NPI: State Lic ID:

Address:

City, State, Zip:

Drug Name: Expedited/Urgent

Directions:

Patient belongs to (please check one): HEALTH PARTNERS KIDZPARTNERS

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:
Q1. What is the requested duration of therapy? 12 months or less More than 12 months
Q2. Does the patient have clinically diagnosed tear deficiency due to ocular inflammation with keratoconjunctivitis sicca? Yes No
Q3. Does the patient have a functioning lacrimal gland? Yes No
Q4. Does the patient use artificial tears at least 4 times per day? Yes No
Q5. Was the prescription written by an ophthalmologist? Yes No
Q6. Additional Information / Comments

Physician Signature **Date**

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