TEXAS MEDICAID
Clinical Edit Prior Authorization
Ophthalmic Immunomodulators:
EYSUVIS, RESTASIS, TYRVAYA, XIIDRA

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: MEDICATION INFORMATION	
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Indicate the drug's formulary status: *(Formulary available at www.txvendordrug.com)

- ☐ Non-Preferred Drug **(NPD or NAP Status, Go to Step 3 - PDL PA Criteria Applies)**
- **OR** ☐ Preferred Drug **(Go to Step 4)**
- **OR** ☐ No Status, Drug is not in a Market Basket **(Go to Step 4)**
- **OR** ☐ N/A as this request is for a CHIP / PERINATE client **(Go to Step 4)**

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 30-day treatment trial with at least 1 preferred agent in the last 180 days?

   ☐ Yes (Go to Step 4, Question 1) ☐ No (Go to #2)

2. Is there a documented allergy or contraindication to preferred agents in this class?

   ☐ Yes (Go to Step 4, Question 1) ☐ No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

   ☐ Yes (Go to Step 4, Question 1) ☐ No (Deny)

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STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Does the client have a diagnosis of dry eye syndrome (DES) or keratoconjunctivitis sicca (KCS) in the last 730 days?

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Is the client less than (<) 16 years of age?

   ☐ Yes (Deny) ☐ No (Go to #3)

3. Is the request for cyclosporine ophthalmic emulsion (RESTASIS)?

   ☐ Yes (Go to #4) ☐ No (Go to #5)

4. Is the client greater than or equal to (≥) 16 years of age?

   ☐ Yes (Go to #9) ☐ No (Deny)

5. Is the request for lifitegrast ophthalmic solution (XIIDRA)?

   ☐ Yes (Go to #6) ☐ No (Go to #7)

6. Is the client greater than or equal to (≥) 17 years of age?

   ☐ Yes (Go to #9) ☐ No (Deny)

7. Is the request for loteprednol etabonate ophthalmic suspension (EYSUVIS) or varenicline tartrate nasal solution (TYRVAYA)?

   ☐ Yes (Go to #8) ☐ No (Deny)

8. Is the client greater than or equal to (≥) 18 years of age?

   ☐ Yes (Go to #9) ☐ No (Deny)

9. Is the requested quantity less than or equal to (≤) the recommended dosing guidelines?

   Recommended dosage is 60 vials per 30 days for RESTASIS or XIIDRA, 8.3 mL per 14 days for EYSUVIS, 5.5 mL per 30 days for RESTASIS MULTIDOSE bottle, and 2 spray bottles (60 sprays per bottle) per 30 days for TYRVAYA.

   ☐ Yes (Approve – 365 days) ☐ No (Deny)

STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.