

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

RESTASIS (cyclosporine)

Patient name: _____ Medicaid or SS# _____

Physician Name: _____ Contact person: _____

Phone#: _____ Ext and options _____ Fax# _____

Pharmacy _____ Pharmacy Phone#: _____

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 (801) 536-0477**

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:

1. Diagnosis only

AUTHORIZATION:

Prior approval is for 1 year

RE-AUTHORIZATION:

Telephone call from physician's office

INFORMATION:

Maximum supply is 1 box of 32 dropperetts/month