



Request for Prior Authorization
Ophthalmic Agents For Presbyopia

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization (PA) is required for ophthalmic agents indicated for presbyopia. Requests will be considered when patient has an FDA approved or compendia indication for the requested drug.

- 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a documented diagnosis of presbyopia; and
3. Patient is aged 40 to 55 years old at start of therapy; and
4. Is prescribed by, or in consultation with an ophthalmologist or optometrist; and
5. Patient has documentation of a therapeutic failure with corrective lenses (eyeglasses or contact lenses), unless contraindicated or clinically significant intolerance.

If criteria for coverage are met, initial requests will be approved for 3 months. Requests for continuation of therapy will be considered under the following conditions:

- 1. Patient has a documented improvement in presbyopia defined as the patient gained 3 lines or more in mesopic, high contrast, binocular distance corrected near visual acuity (DCNVA), without losing more than 1 line (5 letters) of corrected distance visual acuity (CDVA); and
2. Patient is not experiencing adverse effects from the drug.

Non-Preferred

Vuity

Table with 4 columns: Strength, Dosage Instructions, Quantity, Days Supply

Diagnosis:

Prescriber Specialty: Ophthalmologist, Optometrist, Other (specify):

If other, note consultation with ophthalmologist or optometrist: Consultation date:

Physician name, specialty & phone:

Treatment failure with corrective lenses (eyeglasses or contact lenses): Eyeglasses, Contact Lenses

Trial dates:

Reason for failure:

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Medical or contraindication reason to override trial requirements: _____

Requests for continuation therapy:

Does patient have a documented improvement in presbyopia defined as the patient gained 3 lines or more in mesopic, high contrast, binocular DCNVA, without losing more than 1 line (5 letters) of CDVA?

Yes No

Has patient experienced adverse effects from the drug? Yes No

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*