FAX Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization

Ophthalmic Agents For Presbyopia

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
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. Payment for a non-preferred agent will be considered when there is documentation of a previous trial and therapy failure with a preferred agent. Payment will be considered under the following conditions:

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

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

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.*