Verkazia (cyclosporine 0.1%)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Vernal keratoconjunctivitis(VKC) □ □ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Clinical Information:
Is this drug being prescribed to this patient as part of a treatment regimen specified within a sponsored clinical trial? □ Yes □ No
Is prescriber an ophthalmologist? □ Yes □ No

<u>For initial requests</u>:
Does patient have a diagnosis of vernal keratoconjunctivitis(VKC)? □ Yes □ No

Does patient have active severe vernal keratoconjunctivitis(VKC) consistent with grade 3 or 4 of Bonini scale with severe keratitis grade 4 or 5 on the modified Oxford scale? □ Yes □ No Please submit documentation.

Does patient have a mean score of 4 subjective symptoms(photophobia, tearing, itching, and mucous discharge) greater than or equal to 60mm using a 100mm Visual Analogue Scale(where 0 means no symptoms and 100 means the worst that have been ever experienced)? □ Yes □ No Please submit documentation.

Does patient does have any other ocular anomaly other than VKC interfering with the ocular surface including but not limited to trauma, post radiation keratitis, severe blepharitis, rosacea, corneal ulcer? □ Yes □ No

Does patient have abnormal lid anatomy, abnormalities of the nasolacrimal drainage system or blinking function, herpes keratitis, active ocular infection, or history of ocular varicella-zoster infection? □ Yes □ No

Has patient tried at least 2 of the following treatments? □ Yes □ No Please submit documentation.
□ Ophthalmic antihistamines
□ Ophthalmic steroids
□ Ophthalmic mast stabilizer

<u>For renewal requests</u>:

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Does patient have active severe vernal keratoconjunctivitis(VKC) consistent with grade 3 or 4 of Bonini scale with severe keratitis grade 4 or 5 on the modified Oxford scale? □ Yes □ No Please submit documentation.

Does patient have a mean score of 4 subjective symptoms(photophobia, tearing, itching, and mucous discharge) greater than or equal to 60mm using a 100mm Visual Analogue Scale(where 0 means no symptoms and 100 means the worst that have been ever experienced)? □ Yes □ No Please submit documentation.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811

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