Iowa Department of Human Services

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

Request for Prior Authorization

Cyclosporine Ophthalmic Emulsion 0.1% (Verkazia)

(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 cyclosporine 0.1% ophthalmic emulsion (Verkazia). Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

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 diagnosis of moderate to severe vernal keratoconjunctivitis (VKC); and**
3. **Documentation of an adequate trial (2 to 3 weeks) and therapy failure with a preferred topical dual-acting mast cell stabilizer/topical antihistamine (e.g., olopatadine, azelastine); and**
4. **Documentation of an adequate trial (2 to 3 weeks) and therapy failure with a preferred topical ophthalmic corticosteroid (e.g., dexamethasone, prednisolone, fluorometholone, loteprednol); and**
5. **Is prescribed by, or in consultation with an ophthalmologist or optometrist; and**
6. **Is not prescribed in combination with other ophthalmic cyclosporine products.**

The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Initial requests will be approved for 6 months. Additional authorizations will be considered upon documentation of clinical response to therapy.

Non-Preferred

☐ Verkazia

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: _____

Is patient using other ophthalmic cyclosporine products in combination with Verkazia? ☐ Yes ☐ No

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Trial Documentation:

Preferred dual-acting mast cell stabilizer/topical antihistamine:

Drug Name:_____ Strength:_____

Dosing Instructions:_____ Trial start date:_____

Preferred topical ophthalmic corticosteroid: Drug Name:_____ Strength:_____

Dosing Instructions:_____ Trial start date:_____

Medical or contraindication reason to override trial requirements: _____

_____

Requests for continuation therapy:

Has patient demonstrated a positive clinical response to therapy?

☐ No

☐ Yes, please describe: _____

_____

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.*