

OPHTHALMICS, GLAUCOMA AGENTS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Ophthalmics, Glaucoma Agents** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <http://www.dhs.pa.gov/provider/pharmacyservices/index.htm>.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	total # of pages: _____	
Name of office contact:		Prescriber name:	
Contact's phone number:		Specialty:	
LTC facility contact/phone:		State license #:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested: (NOTE: Brand names, where applicable, are listed in italics for reference purposes only.)																			
<input type="checkbox"/> Betagan drop	<input type="checkbox"/> Isopto Carpine 1% drop	<input type="checkbox"/> timolol 0.5% <u>once-daily</u> drop (<i>Istalol</i>)																	
<input type="checkbox"/> betaxolol 0.5% drop (<i>Betoptic</i>)	<input type="checkbox"/> Isopto Carpine 2% drop	<input type="checkbox"/> Timoptic <u>Ocudose droperette</u>																	
<input type="checkbox"/> bimatoprost 0.03% drop (<i>Lumigan 0.03%</i>)	<input type="checkbox"/> Isopto Carpine 4% drop	<input type="checkbox"/> Timoptic XE gel-forming solution																	
<input type="checkbox"/> brimonidine-P 0.15% drop (<i>Alphagan-P 0.15%</i>)	<input type="checkbox"/> Istalol drop	<input type="checkbox"/> Trusopt drop																	
<input type="checkbox"/> Cosopt drop	<input type="checkbox"/> Lumigan 0.01% drop	<input type="checkbox"/> Vyzulta drop																	
<input type="checkbox"/> Cosopt PF drop	<input type="checkbox"/> phospholine iodide 0.125% drop	<input type="checkbox"/> Xalatan drop																	
<input type="checkbox"/> dorzolamide/timolol <u>droperette</u> (<i>Cosopt PF</i>)	<input type="checkbox"/> Rhopressa drop	<input type="checkbox"/> Zioptan drop																	
<input type="checkbox"/> lopicidine 0.5% drop	<input type="checkbox"/> timolol 0.25% gel-forming solution (<i>Timolol XE</i>)	<input type="checkbox"/> _____																	
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Directions:		Quantity:	Refills:																
Diagnosis (<u>submit documentation</u>):		Dx code (<u>required</u>):																	
<p>1. Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred Ophthalmics, Glaucoma Agents? <i>Check all that apply.</i></p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Alphagan-P 0.1% or 0.15% drop</td> <td><input type="checkbox"/> dorzolamide/timolol drop (<i>Cosopt</i>)</td> <td rowspan="12" style="vertical-align: top;"> <input type="checkbox"/> Yes – <i>Submit documentation of medication regimens tried and treatment response, contraindications, and/or intolerances.</i> <input type="checkbox"/> No </td> </tr> <tr> <td><input type="checkbox"/> apraclonidine 0.5% drop (<i>Iopicidine 0.5%</i>)</td> <td><input type="checkbox"/> latanoprost 0.005% drop (<i>Xalatan</i>)</td> </tr> <tr> <td><input type="checkbox"/> Azopt drop</td> <td><input type="checkbox"/> levobunolol 0.5% drop (<i>Betagan</i>)</td> </tr> <tr> <td><input type="checkbox"/> Betoptic-S 0.25% drop</td> <td><input type="checkbox"/> pilocarpine drop (<i>Isopto Carpine</i>)</td> </tr> <tr> <td><input type="checkbox"/> brimonidine 0.2% drop (<i>Alphagan</i>)</td> <td><input type="checkbox"/> Simbrinza drop</td> </tr> <tr> <td><input type="checkbox"/> carteolol 1% drop (<i>Ocupress</i>)</td> <td><input type="checkbox"/> timolol 0.25% or 0.5% drop (<i>Timoptic</i>)</td> </tr> <tr> <td><input type="checkbox"/> Combigan drop</td> <td><input type="checkbox"/> Timoptic 0.25% or 0.5% drop</td> </tr> <tr> <td><input type="checkbox"/> dorzolamide 2% drop (<i>Trusopt</i>)</td> <td><input type="checkbox"/> Travatan Z drop</td> </tr> </table>		<input type="checkbox"/> Alphagan-P 0.1% or 0.15% drop	<input type="checkbox"/> dorzolamide/timolol drop (<i>Cosopt</i>)	<input type="checkbox"/> Yes – <i>Submit documentation of medication regimens tried and treatment response, contraindications, and/or intolerances.</i> <input type="checkbox"/> No	<input type="checkbox"/> apraclonidine 0.5% drop (<i>Iopicidine 0.5%</i>)	<input type="checkbox"/> latanoprost 0.005% drop (<i>Xalatan</i>)	<input type="checkbox"/> Azopt drop	<input type="checkbox"/> levobunolol 0.5% drop (<i>Betagan</i>)	<input type="checkbox"/> Betoptic-S 0.25% drop	<input type="checkbox"/> pilocarpine drop (<i>Isopto Carpine</i>)	<input type="checkbox"/> brimonidine 0.2% drop (<i>Alphagan</i>)	<input type="checkbox"/> Simbrinza drop	<input type="checkbox"/> carteolol 1% drop (<i>Ocupress</i>)	<input type="checkbox"/> timolol 0.25% or 0.5% drop (<i>Timoptic</i>)	<input type="checkbox"/> Combigan drop	<input type="checkbox"/> Timoptic 0.25% or 0.5% drop	<input type="checkbox"/> dorzolamide 2% drop (<i>Trusopt</i>)	<input type="checkbox"/> Travatan Z drop	
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PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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