Neighborhood Health Plan of Rhode Island
Medical Necessity Request Form
Restasis® (Cyclosporine Emulsion)

Date of Request: ______________________

If approval criteria are met, Neighborhood Health Plan of Rhode Island will authorize coverage of Restasis® (Cyclosporine Emulsion). Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance.

Please complete the following information:

Member Name: (required)	**Member ID Number or SSN: (required)**
Member Date of Birth: (required) / /	**Member Sex:** M F (Circle One)
Prescriber Name: (required)	**Contact Person at Office:**
Office Phone number: (required) ( ) -	**Office Fax Number: (required) ( ) -**

Quantity: __________ Day Supply ______ Directions: ____________________________________

Diagnosis_________________________ Length of Treatment: __________________________

Has patient started treatment with the requested drug? ________If yes, how long? ___________

ASSESSMENT OF BENEFIT NEED:

1. Is the prescriber an ophthalmologist or optometrist?
   - ☐ Yes
   - ☐ No
   - ☐ Other (please specify): ____

2. Has this patient been diagnosed with keratoconjunctivitis sicca?
   - ☐ Yes
   - ☐ No
   - ☐ Other (please specify): ____

3. Please indicate which test was used to diagnose this patient:

☐ TBUT
☐ Ocular surface dye-staining (rose bengal, fluorescein, lissamine green)
☐ Schirmer test

4. Are both eyes affected?
   - ☐ Yes
   - ☐ No

5. Please describe which therapies the patient has failed *in the past 6 months*:

☐ OTC Lubricants	☐ Punctal Plugs
☐ Ophthalmic Steroids	☐ Moisture inserts

6. Please indicate your desired outcome with this therapy:
   ____

7. If this is a renewal; has the desired outcome been achieved? YES☐ NO☐

BENEFIT TERMS UPON APPROVAL:

If approved, Restasis will be authorized for one year with yearly renewal if therapy is successful in meeting physician defined outcomes.

All information provided on this form is accurate as of this date.

Provider Signature:___________________NPI_____________ **Date:**____________________

Completed forms should be faxed to:
Customer Service Department
NHPRI
866-423-0945