

**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) <table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>										
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:

- Is the prescriber an ophthalmologist or optometrist?
 Yes
 No
 Other (please specify): _____
- Has this patient been diagnosed with keratoconjunctivitis sicca?
 Yes
 No
 Other (please specify): _____
- Please indicate which test was used to diagnose this patient:

<input type="checkbox"/> TBUT
<input type="checkbox"/> Ocular surface dye-staining (rose bengal, fluorescein, lissamine green)
<input type="checkbox"/> Schirmer test
- Are both eyes affected?
 Yes
 No
- Please describe which therapies the patient has failed *in the past 6 months*:

<input type="checkbox"/> OTC Lubricants	<input type="checkbox"/> Punctal Plugs
<input type="checkbox"/> Ophthalmic Steroids	<input type="checkbox"/> Moisture inserts
- Please indicate your desired outcome with this therapy:

- 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:
Neighborhood Customer Service
866-423-0945**