Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Xiidra (lifitegrast) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Xiidra (lifitegrast)** for **Commercial, Exchange, FEHB (Federal),** and **MD Medicaid** plans. Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103.

Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Provider Name: _____ Specialty: _____ NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Do you have an approved provider referral number from Kaiser Permanente?
□ Yes – please provide your provider referral number here: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____
Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, state start date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Is this medication being prescribed by an Ophthalmologist or Optometrist?
   □ No □ Yes

2. Is the patient ≥18 years of age with a diagnosis of dry eye disease?
   □ No □ Yes

3. Has the patient tried and failed at least one month of one OTC ocular lubricant (e.g., artificial tears, lubricating gels/ointments)?
   □ No □ Yes

4. Has the patient had an adequate trial (3 months' treatment duration) and failure to cyclosporine 0.05% ophthalmic solution (generic Restasis) AND Cequa 0.09%?
   □ No □ Yes

5. Is the patient concomitantly using an ophthalmic cyclosporine product (Cequa, Restasis, Vevye) (therapy will not be approved if so)?
   □ No □ Yes

For continuation of therapy, please respond to <u>additional questions</u> below. New members who were initiated on therapy outside of Kaiser, who have not been reviewed previously, must meet all above Clinical Criteria.

1. Is there documentation of positive clinical response to therapy (e.g., increased tear production or improvement in dry eye symptoms)?
   □ No □ Yes

6 – Provider Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**