STANDARD COMMERCIAL DRUG FORMULARY
PRIOR AUTHORIZATION GUIDELINES

CYCLOSPORINE

Generic	Brand	HICL	GCN	Medi-Span	Exception/Other
CYCLOSPORINE	VERKAZIA		46848	GPI-14 (86720020001630)	

GUIDELINES FOR USE

1. Does the patient have a diagnosis of vernal keratoconjunctivitis **AND** meet the following criterion?
    - The patient had a trial of or contraindication to TWO ophthalmic dual-acting mast cell stabilizer/antihistamines (e.g., ketotifen) or mast cell stabilizers (e.g., cromolyn)

    If yes, **approve for 12 months by GPID or GPI-14 with a quantity limit of #4 vials per day.**
    If no, do not approve.
    DENIAL TEXT: *Some terms are already pre-defined in parenthesis. Please use these definitions if the particular text you need to use does not already have definition(s) in it.

    Our guideline named **CYCLOSPORINE (Verkazia)** requires the following rule(s) be met for approval:
    A. You have vernal keratoconjunctivitis (allergic eye disease)
    B. You had a trial of or contraindication (harmful for) to TWO ophthalmic dual-acting mast cell stabilizer/antihistamines (such as ketotifen) or mast cell stabilizers (such as cromolyn)

    Your doctor told us [INSERT PT SPECIFIC INFO PROVIDED]. We do not have information showing you [INSERT UNMET CRITERIA]. This is why your request is denied. Please work with your doctor to use a different medication or get us more information if it will allow us to approve this request.

RATIONALE
For further information, please refer to the Prescribing Information and/or Drug Monograph for Verkazia.

REFERENCES

- Verkazia [Prescribing Information]. Emeryville, CA: Santen Inc.; June 2022.

Library	Commercial	NSA
Yes	Yes	No

Part D Effective: N/A
Commercial Effective: 10/01/22
Created: 08/22
Client Approval: 09/22
P&T Approval: 07/22

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