OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Xiidra™ Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Dry eye disease (DED)
Is the patient's DED moderate to severe? ❑ **Yes** ❑ **No**
❑ Moderate to severe keratoconjuctivitis sicca (KCS)
❑ Other diagnosis: ______________________________ ICD-10 Code(s): ____________________________________

Clinical information:

Is tear deficiency associated with ocular inflammation due the patient's diagnosis above? ❑ **Yes** ❑ **No**
Is the requested medication prescribed to manage dry eyes peri-operative elective eye surgery (e.g., LASIK)? ❑ **Yes** ❑ **No**
Was the medication prescribed by or in consultation with an ophthalmologist, optometrist, or rheumatologist? ❑ **Yes** ❑ **No**

Medication history:

Does the patient have a trial and failure, contraindication, or intolerance to at least one over-the-counter ocular lubricant used at an optimal dose and frequency for at least two weeks (e.g., artificial tears, lubricating gels/ointments, etc.)? ❑ **Yes** ❑ **No**

Reauthorization:

If this is a reauthorization request, answer the following question:

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

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**
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