**Vyzulta™ Prior Authorization Request Form**

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

<table>
<thead>
<tr>
<th>Member Information (required)</th>
<th>Provider Information (required)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Name:</strong></td>
<td><strong>Provider Name:</strong></td>
</tr>
<tr>
<td>Insurance ID#:</td>
<td>NP#:</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td>Office Phone:</td>
</tr>
<tr>
<td>Street Address:</td>
<td>Office Fax:</td>
</tr>
<tr>
<td>City:</td>
<td>Office Street Address:</td>
</tr>
<tr>
<td>State:</td>
<td>City:</td>
</tr>
<tr>
<td>Zip:</td>
<td>State:</td>
</tr>
<tr>
<td>Phone:</td>
<td>Zip:</td>
</tr>
<tr>
<td><strong>Medication Information (required)</strong></td>
<td><strong>Strength:</strong></td>
</tr>
<tr>
<td>Medication Name:</td>
<td></td>
</tr>
<tr>
<td>Check if requesting brand:</td>
<td></td>
</tr>
<tr>
<td>Check if request is for continuation of therapy:</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Information (required)</strong></td>
<td><strong>ICD-10 Code(s):</strong></td>
</tr>
<tr>
<td>Select the diagnosis below:</td>
<td></td>
</tr>
<tr>
<td>Ocular hypertension</td>
<td></td>
</tr>
<tr>
<td>Open-angle glaucoma</td>
<td></td>
</tr>
<tr>
<td>Other diagnosis:</td>
<td></td>
</tr>
<tr>
<td>ICD-10 Code(s):</td>
<td></td>
</tr>
<tr>
<td>Select the medications the patient has a failure, contraindication, or intolerance to:</td>
<td></td>
</tr>
<tr>
<td>Bimatoprost</td>
<td></td>
</tr>
<tr>
<td>Latanoprost</td>
<td></td>
</tr>
<tr>
<td>Lumigan</td>
<td></td>
</tr>
<tr>
<td>Travatan Z</td>
<td></td>
</tr>
<tr>
<td>Xalatan</td>
<td></td>
</tr>
<tr>
<td>Zioptan</td>
<td></td>
</tr>
<tr>
<td><strong>Quantity limit requests:</strong></td>
<td></td>
</tr>
<tr>
<td>What is the quantity requested per MONTH?</td>
<td></td>
</tr>
<tr>
<td><strong>What is the reason for exceeding the plan limitations?</strong></td>
<td></td>
</tr>
<tr>
<td>Titration or loading-dose purposes</td>
<td></td>
</tr>
<tr>
<td>Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)</td>
<td></td>
</tr>
<tr>
<td>Requested strength/dose is not commercially available</td>
<td></td>
</tr>
<tr>
<td>There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. Please specify:</td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
</tr>
</tbody>
</table>

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

________________________________________________________________________________
________________________________________________________________________________

Please note: This request may be denied unless all required information is received. If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555. 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.