

Health New England
Medication Request Form (MRF)
Restasis® (cyclosporine) 0.05% ophthalmic emulsion

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Prior Authorization

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Restasis®. Please complete this form and fax to MedMetrics Health Partners at (800) 550-9246. If you have any questions regarding this process, please contact MedMetrics clinical call center at (866) 209-1057.

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Information	Physician Information
Patient Name (required):	Physician Name:
	Specialty:
Patient HNE ID# (required):	HNE Provider #:
Patient Date of Birth (required):	DEA # (required):
Allergies:	Area Code and Telephone #: () -
	Area Code and Fax # (required): () -

Drug Information		
Requested Drug / Strength:	Restasis®	
Dose, directions and length of treatment (please be specific):	Quantity (per month):	Refills:
Physician signature:	Date:	
Indication:		
<input type="checkbox"/> Prescribing physician an ophthalmologist, optometrist or rheumatologist, or is the request recommended by an ophthalmologist, optometrist or rheumatologist?		
<input type="checkbox"/> Diagnosis of keratoconjunctivitis sicca (KCS) [dry eye syndrome] .		
<input type="checkbox"/> Diagnosis of Sjögren's syndrome.		
<input type="checkbox"/> Patient being treated for Ocular Graft vs. Host Disease, or corneal transplant rejection?		
<input type="checkbox"/> Patient has an intolerance, contraindication, or had an inadequate response to an alternative dry eye agent (i.e. artificial tears) or has the patient's need for an alternative agent increased over time?		
<input type="checkbox"/> Other (please describe): _____ _____ _____		