



**BlueCross BlueShield  
of North Carolina**

**RESTASIS (cyclosporine ophthalmic emulsion 0.05%)  
PRIOR REVIEW/CERTIFICATION FAXBACK FORM**

**INCOMPLETE FORMS MAY DELAY PROCESSING  
ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT BCBSNC PROVIDER ID# BELOW**

| PRESCRIBER INFORMATION       |   | PATIENT INFORMATION     |
|------------------------------|---|-------------------------|
| PHYSICIAN NAME               | PROVIDER ID/TAX ID (if out of state must have tax ID) | PATIENT NAME            |
| CONTACT PERSON/PRACTICE NAME |   | PATIENT'S BCBSNC ID     |
| PRACTICE PHONE               | PRACTICE FAX  | PATIENT'S DATE OF BIRTH |
| PRACTICE ADDRESS             | CITY  | STATE ZIP               |

**Please answer the following questions:** **Dx Code:** \_\_\_\_\_

1. For which of the following three situations is Restasis (cyclosporine ophthalmic emulsion) being prescribed? *Please check at least one and answer the associated question, if any.*

Treatment of moderate to severe dry eye syndrome (i.e., keratoconjunctivitis sicca)

a. Has the patient required frequent use of ocular lubricating solution or ointment (e.g., ≥3 times per day use of artificial tears) or other treatments such as punctal plugs or goggles for chronic dry eyes? .....  Yes  No

Treatment of corneal inflammatory conditions for which the patient has required extemporaneously compounded cyclosporine ophthalmic preparations

Treatment of dry eye or other symptoms that have occurred as a result of the effects of types of refractive surgery that are not covered.<sup>1</sup> (Coverage is not authorized for Restasis when used as a result of the effects of refractive surgery, which is not covered.)

2. Is the patient under the care of an ophthalmologist, optometrist, or rheumatologist? .....  Yes  No

<sup>1</sup>Radial keratotomy, photorefractive keratectomy, automated lamellar keratoplasty, minimally invasive radial keratotomy, hexagonal keratotomy, keratomileusis, LASIK, LASEK, keratophakia, clear lens extraction, phakic intraocular lens implantation, conductive keratoplasty, laser thermal keratoplasty, astigmatic keratotomy, and intracorneal inlays are not covered. See [http://www.bcbsnc.com/assets/services/public/pdfs/medicalpolicy/refractive\\_surgery.pdf](http://www.bcbsnc.com/assets/services/public/pdfs/medicalpolicy/refractive_surgery.pdf).

**Please certify the following by signing and dating below:**

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): \_\_\_\_\_ Date: \_\_\_\_\_

**For BCBSNC members, fax form to 1-800-795-9403**