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Lumigan® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.

This form may be faxed to 844-403-1029.

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:
	Directions for Use:	

Clinical Information (required)	
1. Select the diagnosis below: ❑ Ocular hypertension ❑ Open angle glaucoma ❑ Other diagnosis: _____ ICD-10 Code: _____	
2. Has the patient demonstrated a failure of or intolerance to a majority (two or more in a class with at least two alternatives or one in a class with only one alternative) of the preferred formulary/preferred drug list alternatives for the given diagnosis (e.g., latanoprost, Travatan Z, travoprost, Zioptan)?	❑ Yes ❑ No
3. Does the patient have a documented contraindication to the listed formulary alternatives (e.g., latanoprost, Travatan Z, travoprost, Zioptan)?	❑ Yes ❑ No
4. Has the patient had an adverse reaction to OR would be reasonably expected to have an adverse reaction to a majority (two or more in a class with at least two alternatives or one in a class with only one alternative) of the listed formulary agents used for the requested indication (e.g., latanoprost, Travatan Z, travoprost, Zioptan)?	❑ Yes ❑ No
5. Does the patient have a clinical condition for which there is no listed formulary agent to treat the condition based on published guidelines or clinical literature?	❑ Yes ❑ No
6. Is the drug being prescribed within the manufacturer's published dosing guidelines or does the dose fall within dosing guidelines found in accepted compendia or current literature (e.g., package insert, AHFS, Micromedex, current accepted guidelines, etc.)?	❑ Yes ❑ No

Information on this form is accurate as of this date.

Prescriber's Signature:	**Date:**

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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.**
For more information about the prior authorization process, please contact us at 855-811-2218.
Monday – Friday: 8 a.m. to 1 a.m. Eastern, and Saturday: 9 a.m. to 6 p.m. Eastern