

Special Authorization Request Form, for:

RESTASIS (cyclosporine), generic cyclosporine

The purpose of this form is to obtain medical information required to assess your request for a drug on the Special Authorization (SA) list of the Reformulary. Please ensure that all information, including contact information, is complete. Completing this form is not a guarantee of approval.

PART 1: COMPLETE THIS INFORMATION

Information about plan member

First name: _____ Last name: _____

Group number: _____ Certificate number: _____

Date of birth (DD/MM/YY): _____ Gender: _____

Address: _____

City/Town: _____ Province: _____ Postal code: _____

Email: _____ Phone: _____

COORDINATION OF BENEFITS

Coverage through another health benefit plan or provincial plan

Do you or your dependents have drug coverage through another health benefits, insurance company or provincial plan? Yes No

If yes, provide the following: Name of plan member: _____

Policy/Plan number: _____ Certificate number: _____

Patient assistance program

Have you enrolled in a patient assistance program? Yes No

If yes, provide your patient assistance program ID number: _____

Provide the patient assistance program:

Contact name: _____ Phone: _____

PART 2: TO BE COMPLETED BY YOUR DOCTOR (PHYSICIAN)

Physician Information

First name: _____ Last name: _____

License: _____ Phone: _____

Address: _____

City/Town: _____ Province: _____ Postal code: _____

Physician's signature: _____

(confirming the below information to be correct)

Drug being requested through Special Authorization

It is recommended that, when appropriate, patient starts on generic cyclosporine.

New request Request for continuation of therapy

DIN: _____ Product name: _____

Strength: _____ Dosage: _____

Site of Administration

Home Private clinic Hospital
 Doctor's office Cancer centre LTC facility

CLINICAL INFORMATION

Diagnosis

Dry eye disease

Physician specialty

Ophthalmologist
 Optometrist (prescribing)

CLINICAL INFORMATION (cont.)

Criteria for initial coverage for dry eye disease, confirm the following:

- Patient is 18 years of age or older; and
- Patient must be diagnosed with moderate to moderately severe (Level 2-3 severity by DEWS Guidelines) aqueous deficient dry eye disease; and
- Patient has failed on at least two products for dry eyes:
 - artificial tears ophthalmic solutions
 - lubricating ointment, gels, emulsions
 - ocular inserts

NOTE: Duration of initial approval is 1 year

Request for continuation of therapy, confirm the following:

- Patient must maintain adequate response to therapy

NOTE: Duration of continued approval is 1 year

SPECIAL NOTES

Describe any intolerances to therapy: _____

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

Date: December 2020