**Dry Eye Treatment**

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| Criteria 1 | Restasis Trays (P, BVG, ST), generic cyclosporine trays (CYCLOSPORINE EMU 0.05% OP)- NP |
| Criteria 2 | Non-preferred agents- Cequa, Restasis Multi-Dose, Tyrvaya, Xiidra |
| Criteria 3 | Eysuvis (NP) |

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| **Criteria Title** | Ophthalmic Agents: Dry Eye Treatments | | |
| **Criteria Subtitle** | Restasis Trays, Cyclosporine Trays | | |
| **Approval Level** | NDC-9 | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| RESTASIS TRAYS | 051820 | GCNSeqNo |
| CYCLOSPORINE EMU 0.05% OP | 051820 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0997 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0998 |
| Continuation (re-authorization request) | 1234 |
| 2 | 0998 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 0999 |
| N | 1235 |
| 3 | 0999 |  | Select | Is the request for Brand Restasis Trays or generic cyclosporine trays (CYCLOSPORINE EMU 0.05% OP)? | Brand Restasis Trays | 1000 |
| Generic cyclosporine trays | 2000 |
| 4 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 14 days with one artificial tear or over-the-counter (OTC) dry eye drop in the previous 120 days?    If yes, please submit the medication trials and dates. | Y | END (Approve x 365 days) |
| N | 1235 |
| 5 | 2000 |  | Select and Free Text | Has the brand medication been attempted and failed or is the brand medication contraindicated?  If yes, please submit the medication trials and dates. | Y | 2002 |
| N | 2001 |
| 6 | 2001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 2002 |
| N | 1236 |
| 7 | 2002 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 2003 |
| N | END (Approve x 365 days) |
| 8 | 2003 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Approve x 365 days) |
| N | 1235 |
| 9 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Approve x 365 days) |
| N | 1235 |
| 10 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 11 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

Length of authorization: 365 days

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| **Last Approved** | 5/18/2023 |
| **Other** |  |

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| **Criteria Title** | Ophthalmic Agents: Dry Eye Treatments | | |
| **Criteria Subtitle** | Cequa, Restasis Multi-Dose, Tyrvaya, Xiidra | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| CEQUA | 078754 | GCNSeqNo |
| RESTASIS MULTI-DOSE | 076793 | GCNSeqNo |
| TYRVAYA | 082768 | GCNSeqNo |
| XIIDRA | 076360 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 1999 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 2000 |
| Continuation (re-authorization request) | 1234 |
| 2 | 2000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 2001 |
| N | 1235 |
| 3 | 2001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 14 days with at least one preferred drug?  The preferred alternatives may include: Restasis Trays.  If yes, please submit the medication trials and dates. | Y | 2003 |
| N | 2002 |
| 4 | 2002 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 2003 |
| N | 1236 |
| 5 | 2003 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 2004 |
| N | END (Approve x 365 days) |
| 6 | 2004 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Approve x 365 days) |
| N | 1235 |
| 7 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Approve x 365 days) |
| N | 1235 |
| 8 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 9 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

Length of authorization: 365 days

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| **Last Approved** | 5/18/2023 |
| **Other** |  |

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| **Criteria Title** | Ophthalmic Agents: Dry Eye Treatments | | |
| **Criteria Subtitle** | Eysuvis | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code(s) | Type of Code (GCNSeqNo, HICL, NDC) |
| EYSUVIS | 081650 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 1999 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 2000 |
| Continuation (re-authorization request) | 1234 |
| 2 | 2000 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 2001 |
| N | 1235 |
| 3 | 2001 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 14 days with at least one preferred drug?  The preferred alternatives may include: Restasis Trays.  If yes, please submit the medication trials and dates. | Y | 2003 |
| N | 2002 |
| 4 | 2002 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 2003 |
| N | 1236 |
| 5 | 2003 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 2004 |
| N | END (Approve x 14 days) |
| 6 | 2004 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | END (Approve x 14 days) |
| N | 1235 |
| 7 | 1234 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | END (Approve x 14 days) |
| N | 1235 |
| 8 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 9 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

Length of authorization: 14 days

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| **Last Approved** | 5/18/2023 |
| **Other** |  |