MEDICATION POLICY

Generic Name: Cyclosporine Ophthalmic Emulsion

Therapeutic Class or Brand Name: Restasis®

Applicable Drugs (if Therapeutic Class)**:** N/A

Date of Origin: 2/1/13 **Date Last Reviewed/Revised:** 12/4/17

GPI Code: 8672002000

Prior Authorization Criteria (may be considered medically necessary when criteria I through II are met):

I. Documented diagnosis of one of the following conditions A through E:

   A. Superficial keratitis.

   B. Punctate keratitis.

   C. Keratoconjunctivitis sicca.

   D. Sicca syndrome - Sjogren's disease.

   E. Cornea replaced by transplant.

II. Minimum age requirement: 16 years old.

Exclusion Criteria:

- N/A

Other Criteria:

- N/A

Quantity/Days Supply Restrictions:

- 60 vials per 30 days.

Approval Length:

- **Authorization:** 1 year.
- **Re-Authorization:** An updated letter of medical necessity or progress notes showing current medical necessity criteria are met and that the medication is effective.

Appendix:

Disclaimer: Medication Policies are developed to help ensure safe, effective and appropriate use of selected medications. They offer a guide to coverage and are not intended to dictate to providers how to practice medicine. Refer to Plan for individual adoption of specific Medication Policies. Providers are expected to exercise their medical judgment in providing the most appropriate care for their patients.

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N/A

References:

1. https://medicaid.utah.gov/pharmacy/priorauthorization/pdf/Restasis.pdf.
2. www.drugs.com.
3. https://npsonline.pti-nps.com.
4. http://www.allergan.com/assets/pdf/restasis_pi.pdf.

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Historical Tracking Of Changes Made To Policy	
12/4/2017	1. Policy reviewed: no changes made.
9/23/2016	1. Policy reviewed: no changes made.
3/11/2015	1. **Removed** "The prescribing provider is an ophthalmologist or with documented ophthalmologist consult" **from Prior Authorization Criteria**. 2. **Updated** "http://www.health.utah.gov/medicaid/pharmacy/priorauthorization/pdf/Restasis.pdf" **to** "https://medicaid.utah.gov/pharmacy/priorauthorization/pdf/Restasis.pdf" **under References**.
1/27/2014	1. **Adapted policy to new format.** 2. **Changed Prior Authorization Criteria from:** "Documented diagnosis of one of the Covered Uses listed below: *370.20 Superficial keratitis, unspecified; *370.21 Punctate keratitis; *370.33 Keratoconjunctivitis sicca, not specified as Sjogren's disease; *710.2 Sicca syndrome - Sjogren's disease; *V42.5 Cornea replaced by transplant; Documented Fluorescein test; Request from ophthalmologist or with documented ophthalmologist consult" **to:** . "I. Documented diagnosis of one of the following conditions A through E: A. Superficial keratitis; B. Punctate keratitis; C. Keratoconjunctivitis sicca; D. Sicca syndrome - Sjogren's disease; E. Cornea replaced by transplant; II. Minimum age requirement: 16 years old; III. The prescribing provider is an ophthalmologist or with documented ophthalmologist consult". 3. **Changed Quantity/Days Supply from** "1 box of 32 dropperettes/month" **to** "60 vials per 30 days". 4. **Changed Re-Authorization under Approval Length from** "Additional with same criteria" **to** "An updated letter of medical necessity or progress notes showing current medical necessity criteria are met and that the medication is effective". 5. **Updated references** to include website address for specific Utah Medicaid policy referred to and updated website address for package insert.

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