TRICARE Prior Authorization Request Form for
lotilaner **(Xdemvy)**

6837

To be completed and signed by the prescriber.

MARTIN'S POINT® HEALTHCARE

Clinical Documentation must accompany form in order for a determination to be made.

Please fax completed form back to: (207) 828-7816

Prior Authorization expires in 6 months; a new PA must be submitted.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is the requested medication prescribed by an ophthalmologist or optometrist?	☐ Yes **Proceed to question 2**	☐ No **STOP** **Coverage not approved**
2. Does the patient have a diagnosis of Demodex blepharitis confirmed by the presence of Demodexmites on microscopic examination? **Note: Non-FDA approved uses are NOT approved, including for dry eye disease or meibomian gland dysfunction.**	☐ Yes **Proceed to question 3**	☐ No **STOP** **Coverage not approved**
3. Does the patient have Demodex infestation with at least 10 eyelashes with collarettes?	☐ Yes **Proceed to question 4**	☐ No **STOP** **Coverage not approved**
4. Is the patient greater than or equal to 18 years of age?	☐ Yes **Proceed to question 5**	☐ No **STOP** **Coverage not approved**
5. Has the patient tried and failed an adequate treatment course with topical tea tree oil?	☐ Yes **Proceed to question 6**	☐ No **STOP** **Coverage not approved**

6. Will the patient continue to practice good eyelid hygiene including eyelid wipes (for example, Ocusoft)?	☐ Yes **Sign and date below**	☐No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____

[14 Feb 2024]