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



6837

To be completed and signed by the prescriber.



## 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.

Patient Name: Address:  Sponsor ID # Date of Birth:  Please complete the clinical assessment:  Please complete the clinical assessment:  1. Is the requested medication prescribed by an ophthalmologist or optometrist?  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.  3. Does the patient have Demodex infestation with at least 10 eyelashes with collarettes?  4. Is the patient greater than or equal to 18 years of age?  Physician Name: Address:  Phone #: Secure Fax #:  O Yes Proceed to question 2  O Yes Proceed to question 3  O Yes Proceed to question 3  O Yes Proceed to question 4  STOP Coverage not approved  O Yes Proceed to question 5  STOP Coverage not approved  O Yes Proceed to question 5  STOP Coverage not approved  O Yes Proceed to question 5  STOP Coverage not approved  O Yes Proceed to question 5  STOP Coverage not approved  O Yes Proceed to question 5  STOP Coverage not approved	tep	Please complete patient and physician information (please print):				
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				Coverage not approved		

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o Yes

	6.	Will the patient continue to practice good eyelid hygiene including eyelid wipes (for example, Ocusoft)?	o Yes Sign and date below	o No STOP Coverage not approved		
Step 3	i coming the distriction in the section my fair medical engineering date.					
		Prescriber Signature	 Date			

[14 Feb 2024]

o No