AmeriHealth Caritas New Hampshire

Rho Kinase Inhibitor

Prior Authorization Drug Approval Form

Date of medication request: (MM/DD/YYYY): ____ / ____ / _____

Patient information and medication requested	
Patient's name:	Medicaid number:
Date of birth:	Gender:
Drug name:	Strength:
Dosing directions:	Length of therapy:

Prescriber information		
Prescriber last name:		Prescriber first name:
Prescriber address:		Prescriber representative:
Specialty:	NPI number:	
Phone #:	Fax #:	

Clinical history
1. Is the patient 18 years of age or older? ☐ Yes ☐ No
2. Does the patient have a diagnosis of ocular hypertension or open-angle glaucoma? ☐ Yes ☐ No
3. Has the patient had an adequate trial and failure of a prostaglandin inhibitor or beta-adrenergic antagonist, or is to be used in conjunction with another medication for glaucoma? ☐ Yes ☐ No If yes, please list treatment failures and provide dates or concurrent treatment:
4. Has the patient had previous glaucoma intraocular surgery or glaucoma laser procedure in the affected eye(s)? ☐ Yes ☐ No
5. Has the patient had ocular surgery or laser treatment within 3 months prior to initiation with the Rho Kinase inhibitor? ☐ Yes ☐ No
6. Does the patient currently have any of the following? ☐ Ocular infection ☐ Inflammation ☐ Blepharitis ☐ Conjunctivitis ☐ Ocular disease
Provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

For renewals only
1. Has the patient demonstrated efficacy (e.g., reduction in IOP)? ☐ Yes ☐ No

Signature of prescriber:_____ Date: _____
(prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.