Prior Authorization Checklist for Chronic Dry Eye Patients

This checklist will help ensure necessary information is captured during the patient encounter to facilitate the efficient processing of a prior authorization (PA) request to the health plan.

■ History of Dry Eye

Some payers will ask for initial onset of dry eye symptoms.

Burning	Tearing	Eye pain	Photosensitivity	Foreign body sensation
Redness	Dryness	Itching	Blurry vision	Contact lens intolerance

■ Diagnosis

Make sure to capture severity of disease: mild, moderate, severe.

Determine diagnosis:

H16.223 Keratoconjunctivitis sicca, not specified as Sjögren's, bilateral

Other, please include ICD-10-CM code plus description

Payer policies may require one or more tests. Some payers also require a copy of the patient's medical records, including chart notes, to support current use or previous failures. Consult the payer's policy for specifics.

Examples:

Tear break-up time

Ocular surface dye staining using fluorescein, rose bengal, or lissamine green dyes

Schirmer test

Fluorescein clearance test/tear function index

Tear osmolarity

MMP-9 elevated concentration in the tears

■ Treatment History

Many payer policies require a lack of therapeutic response to at least two over-the-counter artificial tear agents.

EXAMPLE
(Make sure to capture items below during the patient encounter)

Drug/product type		Drug/ product name	Dose	Frequency of use	Duration with specific dates of use	Outcome	
Artificial tears	Lubricant eye gel					Effective	Suboptimal
Lubricant eye ointment	Topical anti-inflammatory drug					Intolerant	Contraindicated
Punctal plug	Other					Failed	

■ Continuation of Therapy

Capture drug/product name, start date, and document if the patient had a positive clinical response.

Note: This form provides information commonly used by payer plans to determine prior authorization. It is intended for reference only and does not guarantee approval. Please be sure to check payer policies for the most up-to-date information. The decision about which code to report must be made by the provider/physician considering the clinical facts, circumstances, and applicable coding rules, including the requirements to document to the highest level of specificity.

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