HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
ROCKLATAN®, RHOPRESSA®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Rocklatan® (netarsudil and latanoprost ophthalmic solution) 0.02%/0.005%, ☐ Rhopressa® (netarsudil ophthalmic solution) 0.02%

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
1. Is the therapy prescribed by an optometrist or ophthalmologist?	☐	☐	
2. Does the member have a documented diagnosis of open-angle glaucoma or ocular hypertension?	☐	☐	**Please provide documentation**
3. Has the member had a trial and failure, or contraindication/intolerance, to latanoprost in combination with each of the following: • Preferred ophthalmic beta blocker (e.g. timolol, betaxolol) • Preferred alpha-2 adrenergic agonist (e.g. brimonidine) • Preferred carbonic anhydrase inhibitor (e.g. dorzolamide)	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does updated clinical documentation show a positive response to therapy with a stabilization or reduction of intraocular pressure?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:
Physician Signature:

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Policy: PHARM- 114
Origination Date: 12/02/2020
Reviewed/Revised Date: 01/18/2023
Next Review Date: 01/18/2024
Current Effective Date: 02/01/2023