



**New Hampshire AIDS Drug Assistance Program
Prior Authorization Drug Approval Form**

Vuity®

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MEDICAID ID NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

DATE OF BIRTH:

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GENDER:

Male

Female

Drug Name:

Strength:

Dosing Directions:

Length of Therapy:

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

PHONE NUMBER:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

FAX NUMBER:

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SECTION III: CLINICAL HISTORY

- Does the patient have a diagnosis of presbyopia? Yes No
- Is the prescriber an optometrist or ophthalmologist **or** has one been consulted? Yes No
- Does the patient have glaucoma, ocular hypertension, or iritis? Yes No
- Does the patient have a documented contraindication or failure of corrective lenses? Yes No

List failure or note contraindication:

Eyeglasses: _____

Contacts: _____

SECTION IV: FOR RENEWALS ONLY

- Has the patient demonstrated efficacy with improvement in presbyopia? Yes No
- Has the patient experienced any treatment-limiting adverse effects (e.g., retinal detachment, iritis, hypersensitivity)? Yes No



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PATIENT LAST NAME:

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PATIENT FIRST NAME:

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Provide any additional information that would help in the decision-making process. **If additional space is needed, please use another page.**

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.

PRESCRIBER'S SIGNATURE: _____ **DATE:** _____