FAX

Date & Time:	
Deliver To:	
Fax Number:	
From:	
Phone Number:	
Subject:	**INFORMATION REQUESTED** for Prescription Substitution Request

ADDITIONAL INFORMATION REQUESTED REGARDING YOUR PHARMACY'S REQUEST TO SUBSTITUTE

xiidra® (lifitegrast ophthalmic solution) 5%

FOR OFFICE USE: PLEASE COMPLETE BEFORE SENDING TO THE PHARMACY

Patient's Name: _____

Practice/Office Name: _____ **Office Contact:** _____

Office Fax Number: _____ **Office Phone Number:** _____

OUR OFFICE WILL USE THE INFORMATION YOU ENTER BELOW TO FURTHER UNDERSTAND AND EVALUATE YOUR PHARMACY'S REQUEST TO SUBSTITUTE PRESCRIBED MEDICATION FOR THE PATIENT LISTED ABOVE.

FOR PHARMACY USE: PLEASE ANSWER THE FOLLOWING QUESTIONS:

1 Is the patient waiting at your pharmacy for the prescription to be filled?

☐ **YES** (please contact our office for immediate reconciliation) ☐ **NO** (please continue to the next question)

2 What is the patient's prescription plan information (so our office can verify cost, coverage, and other plan requirements)?

Prescription Insurance Plan Name: _____ Plan Phone Number: _____

BIN: _____ PCN: _____ Rx Group: _____

3 What type of medication substitution is being requested?

☐ **Therapeutic Equivalent** ☐ **Generic Substitution** **Drug Name:** _____

4 Was "dispense as written/brand medically necessary/do not substitute" checked on the prescription? ☐ **YES** ☐ **NO**

5 Is this substitution request mandated by the patient's prescription insurance?

☐ **YES:**

◯ 75—Prior Authorization Required ◯ 608—Step Therapy ◯ 70—Product Not Covered

◯ Other Rejection Code: _____ Description: _____

☐ **NO** (please provide reason):

◯ **There is a lower-cost alternative** (alternate medication name): _____

Please provide cost and duration after running the patient's prescription insurance:

MEDICATION	COST	DURATION	DID YOU PROCESS THE XIIDRA SAVINGS CARD?
Prescribed Medication	$	Days	◯ **YES** (cost): $ _____
Alternate Medication	$	Days	◯ **NO** (explanation): _____

◯ **Prescribed medication is out of stock**

How long will it take to fill the prescription? _____ Is there a nearby pharmacy that could fill the prescription? ◯ **Yes** ◯ **No**

◯ **Other** (explanation): _____

PLEASE FAX THIS COMPLETED FORM (ALONG WITH A HIPAA-COMPLIANT COVER SHEET) TO OUR OFFICE (SEE FAX NUMBER AT THE TOP OF THIS FORM).

NOVARTIS

Novartis Pharmaceuticals Corporation
East Hanover, New Jersey 07936-1080

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