**HUSKY Health Program Corneal Collagen Cross-Linking**
**Prior Authorization Request Form**
**Phone: 1.800.440.5071**

**THIS FORM IS TO BE COMPLETED AND SIGNED BY THE ORDERING PROVIDER AND FAXED WITH CLINICAL DOCUMENTATION TO 203.265.3994.**

| **Member Information** | | | |
|---|---|---|---|
| Member ID #: | Member Name (Last, First): | | Date of Service: |
| Address: | | City, State, Zip: | |
| DOB: Sex: | Primary Diagnosis Code: | | Procedure Code: |

| **Please fill out completely** | | |
|---|---|---|
| 1. The corneal collagen cross-linking procedure will use the FDA-approved epithelium-off cross-linking method. | ◯ Yes | ◯ No |
| 2. The patient has a diagnosis of progressive keratoconus or corneal ectasia following refractive surgery. | ◯ Yes | ◯ No |
| 3. Conservative treatment (spectacle correction, rigid contact lenses, etc.) has been tried and is no longer effective in managing the condition. | ◯ Yes | ◯ No |
| 4. The patient does not have a corneal thickness of fewer than 400 microns. | ◯ Yes | ◯ No |
| 5. The patient has not had a prior herpetic ocular infection. | ◯ Yes | ◯ No |
| 6. There is evidence of disease progression. ***If yes, please check all that apply below:***<br>☐ An increase of 1 diopter in the steepest keratometry value<br>☐ An increase of 1 diopter in regular astigmatism evaluated by subjective manifest reaction<br>☐ A myopic shift (decrease in spherical equivalent) of 0.50 diopter on subjective manifest reaction<br>☐ A decrease of ≥ 0.1 mm in the back optical zone radius in rigid contact lens wearers where other information was not available | ◯ Yes | ◯ No |

**Note**: Review criteria are used as guidelines only. Determinations are based on a person-centered assessment of the individual and their unique clinical needs. Additional information submitted with this request will be considered as part of the medical necessity review process, in accordance with Conn. Gen. Stat. Sec. 17b-259b.

| **Billing Provider Information** | | |
|---|---|---|
| Medicaid Billing Number: | | Billing Provider Name: |
| Street Address: | | City, State, Zip: |
| Phone #: | Fax #: | Contact Name: |

| **Ordering Provider Information** | | |
|---|---|---|
| Medicaid Billing Number: | | Ordering Provider Name: |
| Street Address: | | City, State, Zip: |
| Phone #: | Fax #: | Contact Name: |

**Certification Statement:** This is to certify that the requested procedure is medically indicated and is reasonable and necessary for the treatment of this patient and that a prescribing practitioner signed order is on file. This form and any statement on my letterhead attached hereto has been completed by me or by my employee and reviewed by me. The foregoing information is true, accurate and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil and criminal liability.

| **Physician Signature:** | **Date:** |
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