



Date _____

Client _____

PRIOR AUTH QUESTIONNAIRE- HYLIRA™

<i>M.D. Last Name:</i> _____	<i>M.D. First Name:</i> _____
<i>Physician Phone:</i> _____	<i>Physician Fax:</i> _____
<i>Patient</i> _____	<i>ID#</i> _____ <i>DOB</i> _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

1. Please indicate patient's diagnosis:

- Xerosis
- Other diagnosis: _____
 Note: If Other diagnosis is used, please attach a study with efficacy data supporting this request

2. List dates, and attach chart notes to document member's failure on an ammonium lactate-based (Lac-Hydrin/generic) product:

Drug Used/Failed: _____

Dates used: _____

3. List dates, and attach chart notes to document member's failure on a urea based product:

Drug Used/Failed: _____

Dates used: _____

4. Is the patient pregnant? (if NO, skip to signature and comments if needed) Yes No

5. If patient is pregnant, does the potential benefit justify the potential risk to the fetus? Yes No

Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

RESTAT
11900 W. Lake Park Dr.
Milwaukee, WI 53224

QUESTIONS PLEASE CALL:
877-526-9906

www.restat.com

Approval will be for an open-ended period for members who have tried and failed on both an ammonium lactate-based product and a urea-based product.