



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  
P.O. BOX 758  
WEST BEND, WI 53095

QUESTIONS PLEASE CALL:  
**877-526-9906**

[www.restat.com](http://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.