carolina complete health

Eucrisa Temporary PA Request Form

Beneficiary Information

1. Beneficiary Last Name:________________________________ 2. First Name:______________

3. Beneficiary ID #:___________4. Beneficiary Date of Birth:__________ 5. Recipient Gender:_________

Prescriber Information

6. Prescribing Provider NPI#:________________

7. Requester Contact Information: Name:___________________ Phone #: ___________Ext:__________

Drug Information

8. Med requested: **Eucrisa** 9a. Strength: ___________ 9b. Quantity per 30 days _______

9c. Requested Duration ________

10. For areas OTHER than groin or face: Has the patient failed 2 generic topical corticosteroids in the highest potency class and is the patient greater than 2 years of age? Yes_____ No_____

11. For groin and face: Has the patient failed 2 topical generic corticosteroids from preferred list in any potency class (see criteria for list) AND is patient greater than 2 years of age? Yes_____ No_____

12. Does the patient have a documented adverse reaction or contraindication that precludes trial of 2 generic topical corticosteroids from preferred list (see criteria for list)? Yes_____ No_____
Please list: ____

Signature of Prescriber: _______________________________________ Date: _________________

(Prescriber signature mandatory)

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.

Fax this form to: (877) 386-4695 Pharmacy PA Call Center: (833) 585-4309