carolina complete health

Topical Anti-Inflammatory Medications 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: ___Elidel ___Eucrisa ___Protopic 0.03% ____ Protopic 0.1%
___tacrolimus 0.03% (generic) ___tacrolimus 0.1% (generic)
___pimecrolimus (generic)

9. Quantity per 30 days_____9a. Duration_____

For Coverage of Elidel and Eucrisa

1. For areas OTHER than groin or face: Has the beneficiary failed 1 topical corticosteroid in the highest potency class and is the beneficiary greater than 2 years of age? ___YES ___NO

2. For groin and face: Has the beneficiary failed 1 topical corticosteroid in any potency class AND is the beneficiary greater than 2 years of age? ___YES ___NO

3. Does the beneficiary have a documented adverse reaction or contraindication that precludes trial of 1 topical corticosteroid? ___YES ___NO Please List: _____

For Coverage of Protopic 0.03%, tacrolimus 0.03% (generic), and pimecrolimus (generic)

4. Has the recipient tried and failed Elidel or Eucrisa? ___YES ___NO

5. For areas OTHER than groin or face: Has the beneficiary failed 1 topical corticosteroid in the highest potency class and is the beneficiary greater than 2 years of age? ___YES ___NO

6. For groin and face: Has the beneficiary failed 1 topical corticosteroid in any potency class AND is the beneficiary greater than 2 years of age? ___YES ___NO

7. Does the beneficiary have a documented adverse reaction or contraindication that precludes trial of 1 topical corticosteroid? ___YES ___NO Please List: _____

For Coverage of Protopic 0.1%, and tacrolimus 0.1% (generic)

8. Has the recipient tried and failed Elidel or Eucrisa? ___YES ___NO

9. For areas OTHER than groin or face: Has the beneficiary failed 1 topical corticosteroid in the highest potency class and is the beneficiary greater than 18 years of age? ___YES ___NO

10. For groin and face: Has the beneficiary failed 1 topical corticosteroid in any potency class AND is the beneficiary greater than 18 years of age? ___YES ___NO

11. Does the beneficiary have a documented adverse reaction or contraindication that precludes trial of 1 topical corticosteroid? ___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