carolina complete health

Pharmacy Prior Approval Request for

Topical Anti-Inflammatories

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____5. Beneficiary Gender: ____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy (in days): ☐ up to 30 days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

For Eucrisa, Elidel, pimecrolimus, Protopic, and tacrolimus (questions 1-7):

1. Has the beneficiary tried and failed on at least one prescription topical corticosteroid**?** ☐ **Yes** ☐ **No**
2. Does the beneficiary have a documented adverse reaction or contraindication that precludes trial of 1 topical corticosteroid? ☐ **Yes** ☐ **No Please List:** _____

For Non-preferred medication Requests:

3. Has the beneficiary tried and failed any preferred topical anti-inflammatory medications? ☐ **Yes** ☐ **No**
4. Please list any failed medications or contraindications: _____

Please answer the following depending on the requested topical anti-inflammatory:

5. Eucrisa: Is the beneficiary 3 months old or older? ☐ **Yes** ☐ **No**
6. Elidel, pimecrolimus cream, Protopic 0.03%, and tacrolimus 0.03%: Is the beneficiary 2 years of age or older? ☐ **Yes** ☐ **No**
7. Protopic 0.1% and tacrolimus 0.1%: Is the beneficiary 18 years of age or older? ☐ **Yes** ☐ **No**

For Opzelura (questions 8-11)

8. Is the Beneficiary ≥ 12 years old? ☐ **Yes** ☐ **No**
9. Does the beneficiary have a diagnosis of mild to moderate atopic dermatitis? ☐ **Yes** ☐ **No**
10. Is the beneficiary immunocompromised? ☐ **Yes** ☐ **No**
11. Has the beneficiary had a trial and failure of contraindication, or intolerance to ≥ 2 of the following classes: prescription topical corticosteroids, topical calcineurin inhibitor (ex. pimecrolimus, tacrolimus), topical phosphodiesterase-4 inhibitor (ex. crisaborole). ☐ **Yes** ☐ **No**
Please list _____

Opzelura Renewal (questions 8-13)

12. Does the beneficiary have disease improvement and/or stabilization? ☐ **Yes** ☐ **No**
13. Has the beneficiary experienced serious treatment-related adverse events ((e.g., serious infections, lymphoma or other malignancies, non-melanoma skin cancer, major adverse cardiovascular events [MACE], thrombosis, thrombocytopenia, anemia, neutropenia; or lipid elevations)? ☐ **Yes** ☐ **No**

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 (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/