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

1. Has the member tried and failed on at least one prescription topical corticosteroid**?** ☐ **Yes** ☐ **No**
2. Does the member 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 member 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 member 3 months old or older? ☐ **Yes** ☐ **No**
6. Elidel, Pimecrolimus cream, Protopic 0.03%, and Tacrolimus 0.03%: Is the member 2 years of age or older? ☐ **Yes** ☐ **No**
7. Protopic 0.1% and Tacrolimus 0.1%: Is the member 18 years of age or older? ☐ **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/