



Request for Prior Authorization
IMMUNOMODULATORS-TOPICAL

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for topical immunomodulators. Payment for pimecrolimus (Elidel®) or tacrolimus (Protopic®) 0.03% will be considered for non-immunocompromised patients two years of age and older and tacrolimus (Protopic®) 0.1% for patients 16 years of age and older when there is an adequate trial and therapy failure with two preferred topical corticosteroids.

Non-Preferred

- Elidel, Protopic, Tacrolimus Ointment

Strength Usage Instructions Quantity Days Supply

Diagnosis:

Preferred Drug Trial 1: Drug Name& Dose Trial Dates: Failure Reason

Preferred Drug Trial 2: Drug Name& Dose Trial Dates: Failure Reason

Does the patient have an immunocompromised condition? Yes No

If yes, diagnosis:

Affected area to be treated:

Medical or contraindication reason to override trial requirements:

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.) Date of submission

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only.