CONTAINS CONFIDENTIAL PATIENT INFORMATION

Crisaborole (Eucrisa)

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:
Prior Authorization of Benefits Center at 1-844-512-9004
Provider Help Desk 1-800-454-3730

1. Patient information

Patient name: _____

Patient ID #: _____

Patient DOB: _____

Date of Rx: _____

Patient phone #: _____

Patient email address: _____

2. Physician information

Prescribing physician: _____

Physician address: _____

Physician phone #: _____

Physician fax #: _____

Physician specialty: _____

Physician DEA: _____

Physician NPI #: _____

Physician email address: _____

3. Medication	4. Strength	5. Directions	6. Quantity per 30 days
	_____	_____	Specify:_____

7. Diagnosis: _____

8. Approval criteria: CHECK ALL BOXES THAT APPLY

Note: Any areas not filled out are considered not applicable to your patient and MAY AFFECT THE OUTCOME of this request.

Prior authorization is required for Eucrisa (crisaborole). Payment will be considered for patients when the following criteria are met: 1) Patient has a diagnosis of mild to moderate atopic dermatitis; and 2) Patient is within the FDA labeled age; and 3) Patient has failed to respond to good skin care and regular use of emollients; and 4) Patient has documentation of an adequate trial and therapy failure with two preferred medium to high potency topical corticosteroids for a minimum of 2 consecutive weeks; and 5) Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and 6) Patient will continue with skin care regimen and regular use of emollients. 7) Quantities will be limited to 60 grams for use on the face, neck, and groin and 100 grams for all other areas, per 30 days. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Has patient failed to respond to good skin care and regular use of emollients? Yes ☐ No ☐

Document emollient use: Product name, dosing instructions & duration of use: _____

Will patient continue with skin care regimen and regular use of emollients?
Yes ☐ Emollient to be used:_____ No ☐

Preferred Medium to High Potency Corticosteroid Trial 1:
Drug name & dose:_____ Trial dates: _____

Failure reason: _____

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Patient name:_____ **Patient ID #:** _____

Preferred Medium to High Potency Corticosteroid Trial 2:

Drug name & dose:_____ Trial dates: _____

Failure reason: _____

Preferred Topical Immunomodulator Trial:

Drug name & dose:_____ Trial dates: _____

Failure reason: _____

Affected area to be treated:_____

Medical or contraindication reason to override trial requirements: _____

Attach lab results and other documentation as necessary.

Patient name:_____ **Patient ID #:** _____

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.