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Immunomodulators — Topical Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
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	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #: _____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
Preferred: ☐ Pimecrolimus ☐ Protopic **Nonpreferred**: ☐ Elidel ☐ Tacrolimus ointment	_____	_____	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 topical immunomodulators. Payment for non-preferred topical immunomodulator products will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment for pimecrolimus (Elidel®) or tacrolimus (Protopic®) 0.03 percent will be considered for non-immunocompromised patients age 2 and older, and tacrolimus (Protopic®) 0.1 percent for patients age 16 and older when there is an adequate trial, and therapy failure with one preferred topical corticosteroid, except on face or groin. If criteria for coverage are met, requests will be approved for one tube per 90 days to ensure appropriate short-term and intermittent utilization of the medication. Quantities will be limited to 30 grams for use on the face, neck, and groin, and 60 or 100 grams for all other areas. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Diagnosis: _____

Preferred drug trial 1: Drug name and 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.

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.