



CONTAINS CONFIDENTIAL PATIENT INFORMATION
Topical Corticosteroids
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

2. Physician information

Patient name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient phone #: _____ Patient email address: _____	Prescribing physician: _____ Physician address: _____ Physician phone #: _____ Physician fax #: _____ Physician specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician email address: _____
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3. Medication

4. Strength

5. Directions

6. Quantity per 30 days

			Specify: _____
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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 nonpreferred topical corticosteroids. Payment will be considered for patients when there is documentation of adequate trials and therapy failures with at least two preferred, chemically distinct, topical corticosteroid agents within the same potency class or a higher potency class in the past 12 months. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Dosage form: _____

Days supply: _____

Preferred topical corticosteroid trial 1:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____



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

Preferred topical corticosteroid trial 2:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

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.

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