EXPRESS SCRIPTS®

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**

# Picato (ingenol mebutate)

## Prior Authorization of Benefits (PAB) Form

**Complete form in its entirety and fax to:**
**Prior Authorization of Benefits Center at (800) 601- 4829**

| 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 |
|---|---|---|---|
| Picato (ingenol mebutate) | _____ | _____ | Specify: _____ |

**7. DIAGNOSIS:** _____

**8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY**

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

□ Yes □ No Patient is 18 years of age or older

**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.