

ELIDEL/PROTOPIC

PRIOR AUTHORIZATION REQUEST

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date: _____			
SECTION A - PATIENT INFORMATION			
First Name:		Last Name:	
Member ID: _____			
Address: _____			
City:		State:	Zip:
Phone:		DOB:	Allergies:
Primary Insurance:		Policy #:	Group #:
Is the requested medication NEW <input type="checkbox"/> or a CONTINUATION of THERAPY <input type="checkbox"/> ? If so, start date: _____			
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No			
SECTION B - PHYSICIAN INFORMATION			
First Name:		Last Name: _____ M.D./D.O.	
Address: _____		City: _____	State: _____ Zip: _____
Phone: _____	Fax: _____	NPI #: _____	Specialty: _____
Office Contact Name / Fax Attention to: _____			
SECTION C - MEDICAL INFORMATION			
Medication: _____		Strength: _____	Dosing frequency: _____
Directions for use: _____			
Diagnosis (Please be specific & provide as much information as possible): _____			ICD-10 CODE: _____
Is the requested medication intended to be applied topically to the face, axillae (armpit), or genital area for this patient? Yes ___ No ___			
Has the patient been previously treated with at least <u>two</u> topical corticosteroids which resulted in an inadequate response? Yes ___ No ___			
List medications tried and dates of therapy: _____ _____			
Did the patient experience an intolerance/ adverse reactions, or has a documented contraindication, to treatment with at least <u>two</u> topical corticosteroids? Yes ___ No ___			
List medications tried and adverse reaction/intolerance: _____ _____			

Physician Signature: _____ **Date:** _____

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