



This form is based on Express Scripts standard criteria and may not be applicable to all patients; certain plans and situations may require additional information beyond what is specifically requested.

Additional forms available: www.express-scripts.com/pa

Fax completed form to **1-800-357-9577**
If this an **URGENT** request, please call 1-800-417-8164

Patient Information

Patient First Name: _____

Patient Last Name: _____

Patient ID#: _____

Patient DOB: _____

Patient Phone #: _____

Prescriber Information

Prescriber Name: _____

Prescriber DEA/NPI (required): _____

Prescriber Phone #: _____

Prescriber Fax #: _____

Prescriber Address: _____

State: _____ Zip Code: _____

Primary Diagnosis: _____ ICD Code: _____

Please indicate which drug and strength is being requested:

Elidel 1% Topical Cream

Protopic 0.03% Topical Ointment

Protopic 0.1% Topical Ointment

Directions for use (i.e. QD, BID, PRN & Qty): _____

Please complete the clinical assessment:

1. Is the patient currently taking the requested medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
2. Is the patient taking samples or paying 100% out of pocket for the medication being requested? If no, please indicate: <input type="checkbox"/> Requested medication covered under previous insurance plan <input type="checkbox"/> Started medication in hospital <input type="checkbox"/> Other: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
3. For the diagnosis of <u>steroid-induced rosacea or severe uremic pruritis only</u> , has the patient tried at least <u>two</u> first line therapies for the current condition? If yes, please indicate: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
4. Is either Protopic or Elidel to be used for a dermatologic condition around the eyes, eyelids, or genitalia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

<p>5. Has the patient tried one prescription strength topical corticosteroid (may be brand or generic)?</p> <p>If yes, please indicate topical corticosteroids(s) tried and the date of therapy: _____</p> <p>_____</p> <p>_____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
--	------------------------------	-----------------------------

Are there any other comments, diagnoses, symptoms, and/or any other information the physician feels is important to this review?

<p>Prescriber Signature: _____ Date: _____</p> <p>Office Contact Name: _____ Phone Number: _____</p>	
--	--

Based upon each patient’s prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

The document(s) accompanying this transmission may contain confidential health information. This information is intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you received this information in error, please notify the sender immediately and arrange for the return or destruction of the documents.