AmeriHealth Caritas North Carolina

Pharmacy Request for Prior Approval – Topical Anti-Inflammatories

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

Drug Information

8. Drug Name: _____ 9. Strength: _____ 10. Quantity Per 30 Days: _____
11. Length of Therapy: ___up to 30 days ___60 days ___90 days ___120 days ___180 days ___365 days ___Other:_____

Clinical Information

For Eucrisa, Elidel, pimecrolimus, Protopic, and tacrolimus (questions 1-7):

1. Has the beneficiary tried and failed on at least one prescription topical corticosteroid? Yes___ No___
2. Does the beneficiary have a documented adverse reaction or contraindication that precludes trial of 1 topical corticosteroid? Yes___ No___ Please list: _____

For Non-preferred medication requests:

3. Has the beneficiary tried and failed any preferred topical anti-inflammatory medications? Yes___ No___
4. Please list any failed medications or contraindications: _____
_____

Please answer the following depending of the requested topical anti-inflammatory:

5. Eucrisa: Is the beneficiary 3 months old or older? Yes___ No___
6. Elidel, Pimecrolimus cream, Protopic 0.03%, and Tacrolimus 0.03%: Is the beneficiary 2 years of age or older? Yes___ No___
7. Protopic 0.1% and Tacrolimus 0.1%: Is the beneficiary 18 years of age or older? Yes___ No___

For Opzelura (questions 8-11):

8. Is the Beneficiary ≥ 12 years old? Yes___ No___
9. Does the beneficiary have a diagnosis of mild to moderate atopic dermatitis? Yes___ No___
10. Is the beneficiary immunocompromised? Yes___ No___
11. Has the beneficiary had a trial and failure, contraindication, or intolerance to ≥ 2 of the following classes: prescription topical corticosteroids, topical calcineurin inhibitor (ex. pimecrolimus, tacrolimus), topical phosphodiesterase-4 inhibitor (ex. crisaborole)? Yes___ No___
Please list _____

Opzelura Renewal (questions 8-13):

12. Does the beneficiary have disease improvement and/or stabilization? Yes___ No___
13. Has the beneficiary experienced serious treatment-related adverse events ((e.g., serious infections, lymphoma or other malignancies, non-melanoma skin cancer, major adverse cardiovascular events [MACE], thrombosis, thrombocytopenia, anemia, neutropenia; or lipid elevations)? Yes___ No___

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406