pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

IMMUNOMODULATORS, ATOPIC DERMATITIS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Immunomodulators, Atopic Dermatitis** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm.

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested:	☐Eucrisa ointment (*preferred, clinical PA required)* ☐tacrolimus 0.03% ointment *(non-preferred)* ☐tacrolimus 0.1% ointment *(non-preferred)*		
Directions:		Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	
1. ***Requests for tacrolimus ointment:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred topical calcineurin inhibitors? Check all that apply. ☐Elidel cream ☐Protopic ointment		☐Yes – *Submit all supporting documentation of preferred agent tried and treatment outcome, including contraindications or intolerances.* ☐No	
2. ***Requests for Eucrisa ointment:*** Does the beneficiary have a history of trial and failure, contraindication, or intolerance to topical calcineurin inhibitors? Check all that apply. ☐Elidel cream ☐Protopic/tacrolimus ointment		☐Yes – *Submit all supporting documentation of agents tried and treatment outcome, including contraindications or intolerances.* ☐No	

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: