

IMMUNOMODULATORS, ATOPIC DERMATITIS PRIOR AUTHORIZATION FORM *(form effective 1/9/2023)*

Prior authorization guidelines for Immunomodulators, Atopic Dermatitis and Quantity Limits/Daily Dose Limits are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			NPI:	State license #:
LTC facility contact/phone:			Street address:	
Beneficiary name:			City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Drug requested:	Strength/formulation:	
Directions:	Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):	Diagnosis code (<i>required</i>):	

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

- For a non-preferred topical calcineurin inhibitor:**
 - Tried and failed or has a contraindication or an intolerance to the preferred topical calcineurin inhibitors (*Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.*)
- For a topical JAK inhibitor (eg, Opzelura [ruxolitinib]) OR a topical PDE4 inhibitor (eg, Eucrisa [crisaborole]):**
 - Tried and failed or has a contraindication or an intolerance to a 4-week trial of a topical corticosteroid approved or medically accepted for the beneficiary's diagnosis
 - Tried and failed or has a contraindication or an intolerance to an 8-week trial of a topical calcineurin inhibitor (eg, pimecrolimus, tacrolimus) approved or medically accepted for the beneficiary's diagnosis
- For all other non-preferred TOPICAL Immunomodulators, Atopic Dermatitis:**
 - Tried and failed or has a contraindication or an intolerance to the preferred topical Immunomodulators, Atopic Dermatitis approved or medically accepted for the beneficiary's diagnosis (*Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.*)
- For a targeted systemic Immunomodulator, Atopic Dermatitis (eg, Adbry, Cibinqo, Rinvoq):**
 - Is prescribed the medication by or in consultation with an appropriate specialist (eg, dermatologist)
 - For the treatment of atopic dermatitis:** Tried and failed or has a contraindication or an intolerance to at least TWO of the following (*check all that apply*):

- One of the following:
- For the face, skin folds, or other critical areas, a 4-week trial of a low-potency (or higher) topical corticosteroid
 - For other body areas, a 4-week trial of a medium potency or higher topical corticosteroid
 - An 8-week trial of a topical calcineurin inhibitor (eg, pimecrolimus, tacrolimus)
 - Phototherapy / photochemotherapy (eg, PUVA, UVB light)
 - Systemic immunosuppressives (eg, azathioprine, cyclosporine, methotrexate, mycophenolate)

For the treatment of all other diagnoses:

- List other treatments tried (including start/stop dates, dose, outcomes, etc.): _____
- _____

For an oral JAK inhibitor (eg, Cibinqo, Rinvoq):

- Tried and failed at least one biologic as recommended in the JAK inhibitor's package labeling
- Has a contraindication or an intolerance to biologics as recommended in the JAK inhibitor's package labeling
- Is currently taking an oral JAK inhibitor

For a NON-PREFERRED targeted systemic Immunomodulator, Atopic Dermatitis:

- Tried and failed or has a contraindication or intolerance to the preferred targeted systemic Immunomodulators, Atopic Dermatitis approved or medically accepted for the beneficiary's condition (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.)
- Is currently using the requested non-preferred targeted systemic Immunomodulator, Atopic Dermatitis
 - What is the date of the beneficiary's last dose? _____

RENEWAL requests

1. For a non-preferred topical calcineurin inhibitor:

- Has documented evidence of improvement of disease severity
- Tried and failed or has a contraindication or an intolerance to the preferred topical calcineurin inhibitors (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.)

2. For a topical JAK inhibitor (eg, Opzelura [ruxolitinib]) OR a topical PDE4 inhibitor (eg, Eucrisa [crisaborole]):

- Has documented evidence of improvement of disease severity

3. For all other non-preferred TOPICAL Immunomodulators, Atopic Dermatitis:

- Has documented evidence of improvement of disease severity
- Tried and failed or has a contraindication or an intolerance to the preferred topical Immunomodulators, Atopic Dermatitis approved or medically accepted for the beneficiary's diagnosis (Refer to <https://papdl.com/preferred-drug-list> for a list of preferred and non-preferred drugs in this class.)

4. For a targeted systemic Immunomodulator, Atopic Dermatitis (eg, Adbry, Cibinqo, Rinvoq):

- Has documented evidence of improvement of disease severity
- Is prescribed the medication by or in consultation with an appropriate specialist (eg, dermatologist)

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

Prescriber Signature:

Date:

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