

**TOPICAL IMMUNOMODULATORS
(ELIDEL/PROTOPIC)
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM**

ONLY the prescriber may complete and fax this form. This form is for prospective, concurrent, and retrospective reviews.

Incomplete forms will be returned for additional information. The following documentation is required for prior authorization consideration. For formulary information and to download additional forms, please visit

https://www.bcbstx.com/provider/medicaid/star_kids_prior_auth.html

PATIENT AND INSURANCE INFORMATION

Today's Date: _____

Patient Name (First):		Last:		M:	DOB (mm/dd/yy):
Patient Address:			City, State, Zip:		Patient Telephone:
BCBSTX ID Number:			Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:		Prescriber NPI#:		Specialty:	Contact Name:
Clinic Name:			Clinic Address:		
City, State, Zip:			Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis- ICD code plus description: _____

Medication Requested: _____ Strength: _____

Dosing Schedule: _____ Quantity per Month: _____

- Is the patient currently treated with the requested medication? Yes No
If yes, when was treatment with the requested medication started? _____
- Does the patient have a history of a topical steroid or nystatin/triamcinolone prescription in the last 90 days? Yes No
If no, does the patient have a history of a topical steroid or nystatin/triamcinolone prescription in the last 730 days? Yes No
- Does the patient have a history of a prior pimecrolimus/tacrolimus prescription in the last 365 days? Yes No
- Does the patient have a history of a prior pimecrolimus/tacrolimus prescription less than or equal to (\leq) 84 days in the last 112 days? Yes No
- Does the patient have a diagnosis of atopic dermatitis in the last 730 days? Yes No
- Does the patient have a diagnosis of HIV or immune system disorder in the last 730 days? Yes No
- Does the patient have a history of HIV drugs or immunosuppressants in the last 730 days? Yes No
- Does the patient have a history of antineoplastic agents in the last 730 days? Yes No
- Please list the medications the patient has **previously tried and failed for treatment of this diagnosis** (Please specify if brand name, generic, extended-release products, or over-the-counter products):
 _____ Date(s): _____ Date(s): _____
 _____ Date(s): _____ Date(s): _____
 _____ Date(s): _____ Date(s): _____
- Please list all reasons for selecting the **requested medication** over alternatives (e.g., contraindications, allergies or history of adverse drug reactions). _____

- Please list all other medications the patient is **currently taking** for treatment of this diagnosis. _____

Prescriber or Authorized Signature: _____

Date: _____

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility Authorization does not guarantee payment.

Please fax or mail this form to:

Prime Therapeutics LLC, Clinical Review Department
2900 Ames Crossing Road
Eagan, Minnesota 55121

TOLL FREE

Fax: 877.243.6930 Phone: 855.457.1200

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