

Prior Authorization Request Form for Elidel/Protopic

Member Information

Patient Name _____
 Cardholder ID _____
 Date of Birth _____
 Address _____
 City, State Zip _____
 Phone Number _____

Provider Information

Provider Name _____
 DEA Number _____
 Address _____
 City, State and Zip _____
 Phone Number _____
 FAX Number _____

Pharmacy Information

Pharmacy Name _____ Address _____ Phone _____

Criteria for Approval:

1. Topical requested: *Check one:*

Elidel **Protopic**

2. Is the patient 2 years of age or older? Yes No

3. Diagnosis of atopic dermatitis? *Check one:*
 Mild Moderate Severe

4. Has the patient tried and failed at least two various potency of the following corticosteroids? Yes No

Medium Potency

triamcinolone acetonide
 fluocinolone acetonide
 fluandrenolide
 mometasone furoate
 clocortolone pivalate
 betamethasone valerate
 hydrocortisone butyrate
 hydrocortisone buteprate
 desoximetasone
 prednicarbate

High Potency

fluocinonide
 triamcinolone acetonide
 halcononide emollient
 betamethasone dipropionate
 desoximetasone
 amcinonide

Very High Potency

clobetasol propionate
 diflorasone diacetate
 clobetasol propionate
 betamethasone dipropionate
 (augmented)

5. Does the patient have any contraindications or allergies to all corticosteroids (not the vehicle)? Yes No

Provider Signature _____ Date _____

Fax completed forms to (866) 284-4509.

For Office Use Only

Date/Time Received _____

Reference Number _____

Approved / Denied (Circle One) by _____ Date _____

Date/Time Returned to Provider _____

If you have any questions regarding this form, contact the Prior Authorization Department Toll Free at (866) 284-4492 or FAX Toll Free at (866) 284-4509.

FOX Rx Care Utilization Management
 3375-I Capital Circle NE
 Tallahassee, FL 32308

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