FORM # FRX008

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	High Potency	Very High Potency
triamcinolone acetonide	fluocinonide	clobetasol propionate
fluocinolone acetonide	triamcinolone acetonide	diflorasone diacetate
fluandrenolide	halcononide emollient	clobetasol propionate
mometasone furoate	betamethasone dipropionate	betamethasone dipropionate
clocortolone pivalate	desoximetasone	(augmented)
betamethasone valerate	amcinonide	
hydrocortisone butyrate		
hydrocortisone buteprate		
desoximetasone		
prednicarbate		

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/TimeReceived_____

ReferenceNumber_____

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

FOX Rx Care
We take your coverage personally.