

## IMMUNOMODULATORS, ATOPIC DERMATITIS PRIOR AUTHORIZATION FORM

- Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.
- To review the prior authorization guidelines for Immunomodulators, Atopic Dermatitis agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Immunomodulators, Atopic Dermatitis** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

PRIOR AUTHORIZATION INFORMATION			PRESCRIBER INFORMATION		
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA# _____)	# of pages in request: _____	Prescriber name:		
Name of office contact:			Specialty:		
Contact's phone number:			State license #:		
LTC facility contact/phone:			NPI:	MA Provider ID#:	
RECIPIENT INFORMATION			Street address:		
Recipient Name:			Suite #:	City/state/zip:	
Recipient ID#:	DOB:	Phone:	Fax:		

### CLINICAL INFORMATION

<b>Non-preferred medication requested:</b>	<input type="checkbox"/> Protopic 0.03% ointment <input type="checkbox"/> Protopic 0.1% ointment	<input type="checkbox"/> tacrolimus 0.03% ointment <input type="checkbox"/> tacrolimus 0.1% ointment
Directions:	Quantity:	Refills:
Diagnosis ( <i>submit documentation</i> ):	DX code ( <i>required</i> ):	
1. Does the Recipient have a history of trial and failure, contraindication, or intolerance of the preferred Immunomodulators, Atopic Dermatitis agent, <u>Elidel 1% cream</u> ?	<input type="checkbox"/> Yes – <u>submit all supporting documentation of preferred agent tried and treatment outcome, including contraindications or intolerances</u> <input type="checkbox"/> No	

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

Prescriber Signature:	Date:
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