OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. If the following information is NOT complete, correct, or legible, the authorization will be delayed.

Immunomodulators Atopic Dermatitis

<table>
<thead>
<tr>
<th>Preferred Drugs</th>
<th>Non-Preferred Drugs</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Elidel® (pimecrolimus)</td>
<td>☐ Eucrisa™ (crisaborole)</td>
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<tr>
<td></td>
<td>☐ Protopic® (tacrolimus)</td>
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<tr>
<td></td>
<td>☐ tacrolimus (generic)</td>
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</tbody>
</table>

**DRUG INFORMATION:** Complete information below or authorization process will be delayed.

- **Drug Name/Form/Strength:** 
- **Dosing Schedule:** _______________  **Length of Therapy:** _______________
- **Diagnosis:** _______________  **ICD Code, if applicable:** _______________
- **Length of Authorization:** 1 year

**CLINICAL CRITERIA:** The following criteria MUST be met or authorization will be delayed.

- Member MUST have an FDA approved diagnosis of **Atopic Dermatitis**
- **For Elidel®**
  - Mild to moderate and patient is > 2 years old
    - **AND**
      - Failure to **topical corticosteroids** (i.e., desonide, fluticasone propionate, hydrocortisone butyrate, etc.).
- **Eucrisa™**:
  - Mild to moderate and patient is > 2 years old
    - **AND**
      - Failure to **topical corticosteroids** (i.e., desonide, fluticasone propionate, hydrocortisone butyrate, etc.).
      - **AND**
        - Failure of Elidel®

(continued on next page)
For Protopic® and tacrolimus:

- Protopic® 0.03%: moderate to severe for ages > 2 years
- Protopic® 0.1%: moderate to severe for ages > 18 years

AND

- Failure to topical corticosteroids (i.e., desonide, fluticasone propionate, hydrocortisone butyrate, etc.).

AND

- Failure of Elidel®

**Use of samples to initiate therapy does not meet step edit/preauthorization criteria.**

*Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*