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. **Incomplete form will delay authorization process.**

Immunomodulators Atopic Dermatitis

Drug Requested (please select applicable drug below)**:**	
Preferred Drugs ❑ **Elidel**® (pimecrolimus)	**Non-Preferred Drugs** ❑ **Eucrisa**™ (crisaborole) ❑ **Protopic**® (tacrolimus) ❑ **tacrolimus** (generic)

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 process will be delayed.

- **For Elidel®:**
  - ❑ Patient must have an FDA-approved diagnosis of atopic dermatitis

    AND
  - ❑ Atopic dermatitis is mild to moderate and patient is > 2 years old

    AND
  - ❑ Failure of at least 2 topical corticosteroids (i.e., desonide, fluticasone propionate, hydrocortisone butyrate; etc.) – please list below

    1. _____ 2. _____

- **For Eucrisa™, Protopic® and tacrolimus**:
  - ❑ Patient must have an FDA-approved diagnosis of atopic dermatitis

    AND

(continued on next page)

- ❑ **Eucisa**™: for mild to moderate for ages > 2 years.
- ❑ **Protopic**® 0.03%: moderate to severe for ages > 2 years
- ❑ **Protopic**® 0.1%: moderate to severe for ages > 18 years

AND

- ❑ Failure of **at least 2** **topical corticosteroids** (i.e., desonide, fluticasone propionate, hydrocortisone butyrate, etc.).

AND

- ❑ Failure of Elidel®

- List at least **2 topical corticosteroid drugs** below that were tried and failed:

1. _____ 2. _____

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.*

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***REVISED/UPDATED:** ~~6/29/2017~~; ~~8/29/2017~~; ~~8/18/2018~~; **12/11/2018**