Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Topical Corticosteroids Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

What is the patient's diagnosis for the medication being requested? _____
ICD-10 Code(s): _____

Select if the patient has a trial and failure to any of the following generic topical medications:

- ❑ Alclometasone dipropionate
- ❑ Amcinonide
- ❑ Augmented betamethasone
- ❑ Betamethasone dipropionate
- ❑ Betamethasone valerate
- ❑ Clobetasol
- ❑ Clocortolone pivalate
- ❑ Desonide
- ❑ Desoximetasone
- ❑ Diflorasone
- ❑ Fluocinolone
- ❑ Fluocinonide
- ❑ Fluticasone
- ❑ Halobetasol
- ❑ HC butyrate
- ❑ HC valerate
- ❑ Hydrocortisone 2.5%
- ❑ Mometasone
- ❑ Prednicarbate
- ❑ Triamcinolone

****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.

Prescriber Signature: _____ **Date:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.