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)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
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)

Select the requested drug below:

- ❑ Apexicon E
- ❑ Calcipotriene-betamethasone dipropionate
- ❑ Capex
- ❑ Clobetasol spray
- ❑ Enstilar
- ❑ Fluocinonide cream
- ❑ Flurandrenolide cream
- ❑ Flurandrenolide lotion
- ❑ Flurandrenolide ointment
- ❑ Halog cream
- ❑ Halog ointment
- ❑ Hydrocortisone lipophilic
- ❑ Nolix
- ❑ Pandel
- ❑ Texacort
- ❑ Triamcinolone spray
- ❑ Trianex

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.