UnitedHealthcare Community Plan

Atopic Dermatitis Agents- Topical Phosphodiesterase 4 (PDE4) Inhibitors - Washington

Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**

This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.

Allow at least 24 hours for review.

Section A – Member Information		
First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information				
First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information	
Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS:

- **Does the patient have a diagnosis of atopic dermatitis (eczema)? □ Yes □ No**
  If no, list diagnosis: _____

Requests for CHILDREN AND ADOLESCENTS:

- **Does the patient have history of failure to achieve or maintain remission of low or mild disease, intolerance, or is it clinically inappropriate to use 2 medium potency topical corticosteroids for daily treatment of minimum 14-days each in the previous 6 months? □ Yes □ No**
  (If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

Requests for ADULTS:

- **Does the patient have history of failure to achieve or maintain remission of low or mild disease, intolerance, or is it clinically inappropriate to use 2 high or very high potency topical corticosteroids for daily treatment of minimum 14-days each in the previous 6 months? □ Yes □ No**
  (If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- **Does the patient have contraindication(s) to all PDL topical corticosteroids? □ Yes □ No**
  (If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- **Does the patient have history of failure to achieve or maintain remission of low or mild disease or intolerance, contraindication or is clinically inappropriate to daily use of topical calcineurin inhibitors (e.g. pimecrolimus, tacrolimus) for at least 28 days?**
  (If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)

- **Will Eucrisa be used more than twice daily? □ Yes □ No**

Requests for CONTINUATION OF THERAPY:

- **Is there documentation of positive clinical response? □ Yes □ No**

Provider Signature: _____ **Date:** _____