

Atopic Dermatitis Agents,

Topical Immunosuppressive - Washington

Prior Authorization Request Form

Please complete this <u>entire</u> 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 Inform	nation								
First Name:	Last Name:			Memb	Member ID:				
Address:					•				
City:	State:			ZIP Code:					
Phone:	DOB:			Allergies:					
Primary Insurance Information	(if any):	I			1				
Is the requested medication	on: New or	Continuat	ion of Thera	py? If continuation,	list sta	rt date:			
Is this patient currently hospitalized? Yes No If recently discharged, list discharge date:									
Section B - Provider Inforn	nation								
First Name:			Last Name:				M.D./D.O.		
Address:			City:		State:		ZIP code:		
Phone:	Fax:		NPI #:		Specia	Specialty:			
Office Contact Name / Fax atte	ntion to:								
Section C - Medical Inform	ation								
Medication:					Strength:				
Directions for use:						Quantity:			
Diagnosis (Please be specific & provide as much information as possible): ICD-10 CODE:									
Is this member pregnant?		lf yes,	what is this	member's due date?					
Section D – Previous Medic Medication Name	cation Trials Strength	Dire	ctions	Dates of Therap	y	, Reason for failure / discontinuation			
						41000			
Section E – Additional info	ormation and Ex		of why prefe	erred medications wo	ould no	t meet the	patient's needs:		
	Please refer to	the patient	rs PDL for a	l list of preferred alte	rnative	15			



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 Does the patient have a diagnosis of atopic dermatitis (eczema)? □ Yes □ No If no, list diagnosis:	Member First name:	Member Last name:	Member DOB:
 Does the patient have a diagnosis of atopic dermatitis (eczema)? Yes No If no, list diagnosis:		Clinical and Drug Specifi	c Information
If no, list diagnosis:	ALL REQUESTS:		
Requests for CHILDREN AND ADOLESCENTS: • Does the patient have history of failure to achieve and maintain remission of 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 and maintain remission of 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) Requests for ADULTS: • Does the patient have history of failure to achieve and maintain remission of 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 a contraindication to all PDL topical corticosteroids? □ Yes □ No Requests for CONTINUATION OF THERAPY: • Is there documentation of positive clinical response? □ Yes □ No If yes, list response:			
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 Does the patient have a contraindication to all PDL topical corticosteroids? Yes No Requests for CONTINUATION OF THERAPY: Is there documentation of positive clinical response? Yes No If yes, list response: 			
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- Is there documentation of positive clinical response? Yes No If yes, list response:	- Does the patient have a co	ntraindication to all PDL topical cortico	steroids? 🗆 Yes 🗆 No
If yes, list response:	Requests for CONTINUATION	I OF THERAPY:	
Drevider Signature:			
Drevider Signature.			
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