

TOPICAL IMMUNOMODULATORS

PRIOR AUTHORIZATION REQUEST

PRESCRIBER FAX FORM

ONLY the prescriber may complete and fax this form. This form is for prospective, concurrent, and retrospective reviews.

Incomplete forms will be returned for additional information. The following documentation is required for prior authorization consideration. For formulary information and to download additional forms, please visit

https://www.bcbstx.com/provider/medicaid/star_kids_prior_auth.html

PATIENT AND INSURANCE INFORMATION

Today's Date:

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):
Patient Address:		City, State, Zip:	Patient Telephone:
BCBSTX ID Number:		Group Number:	

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:		Clinic Address:	
City, State, Zip:		Phone #:	Secure Fax #:

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis- ICD code plus description:
Medication Requested: _____ Strength: _____
Dosing Schedule: _____ Quantity per Month: _____

FOR ALL REQUESTS:

1. Is the patient currently treated with the requested medication? Yes No

If yes, when was treatment with the requested medication started? _____

2. Does the patient have a diagnosis of atopic dermatitis or nonsegmental vitiligo in the last 730 days? Yes No

3. Does the patient have a history of a topical steroid prescription in the last 365 days? Yes No

If no, does the patient have a history of a topical steroid prescription in the last 730 days? Yes No

4. Please list all agents the patient has **previously tried and failed for treatment of this diagnosis** (Please specify if the patient has tried brand-name products, generic products, or over-the-counter products. Please specify start and end dates of drugs tried).

_____ Date(s): _____ Date(s): _____
_____ Date(s): _____ Date(s): _____
_____ Date(s): _____ Date(s): _____

5. Please list all reasons for selecting the requested **agent, strength, dosing schedule, and quantity over alternatives** (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). _____

6. Please list all other medications the patient will take **in combination** with the requested medication for the treatment of this diagnosis. _____

FOR TACROLIMUS AND ELIDEL REQUESTS:

7. Has the patient taken Elidel (pimecrolimus) or Protopic (tacrolimus) in the last 90 days? Yes No

8. Does the patient have claims history of prior Elidel (pimecrolimus) or Protopic (tacrolimus) use for less than or equal to 180 days in the last 200 days? Yes No

9. Does the patient have a diagnosis of HIV or immune system disorder in the last 730 days? Yes No

10. Does the patient have a history of HIV drugs or immunosuppressants in the last 730 days? Yes No

11. Does the patient have a history of antineoplastic agents in the last 730 days? Yes No

12. Does the patient have a diagnosis of a skin absorption disorder or a skin malignancy in the last 730 days? Yes No

Please continue to the next page.

Patient name (First):	Last:	M:	DOB (mm/dd/yy):
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FOR OPZELURA REQUESTS:

13. Has the patient taken Elidel (pimecrolimus), Eucrisa (crisaborole), or Protopic (tacrolimus) in the last 90 days? .. Yes No
14. Has the patient had a serious active infection (including hepatitis B virus and/or tuberculosis) in the last 180 days? Yes No
15. Will the patient have concurrent therapy with therapeutic biologics, other JAK inhibitors or potent immunosuppressives? Yes No
16. Has the patient had therapy with a strong CYP3A4 inhibitor in the last 90 days?..... Yes No
17. Has the patient previously used Opzelura (ruxolitinib) cream for less than or equal to 56 days in the last 200 days? Yes No

FOR ZORYVE REQUESTS:

18. Does the patient have a diagnosis of plaque psoriasis in the last 730 days?..... Yes No
19. Does the patient have a diagnosis of moderate to severe hepatic impairment in the last 365 days? Yes No
20. Does the patient have a diagnosis of seborrheic dermatitis in the last 730 days? Yes No

Prescriber or Authorized Signature: _____ **Date:** _____

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility Authorization does not guarantee payment.

Please fax or mail this form to:
 Prime Therapeutics LLC, Clinical Review Department
 2900 Ames Crossing Road Suite 200
 Eagan, Minnesota 55121

TOLL FREE

Fax: 877.243.6930 Phone: 855.457.1200

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