OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Elidel® (pimecrolimus) & Protopic® (tacrolimus ointment) 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 diagnosis below:
❑ Atopic dermatitis
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:
Is the affected area sensitive (i.e., face, axillae, groin)? ❑ **Yes** ❑ **No**
If **yes,** please specify affected area that drug is being prescribed for: _____

Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Alclometasone
❑ Amcinonide
❑ Augmented betamethasone
❑ Betamethasone
❑ Calcipotriene-betamethasone
❑ Clobetasol
❑ Clocortolone
❑ Desonide
❑ Desoximetasone
❑ Diflorasone
❑ Fluocinolone
❑ Fluocinonide
❑ Flurandrenolide
❑ Fluticasone
❑ Halog
❑ Halobetasol
❑ Hydrocortisone
❑ Mometasone
❑ Pramoxine-HC
❑ Prednicarbate
❑ Triamcinolone
❑ Other prescription strength topical corticosteroid(s). Please specify: _____

Quantity limit requests:
What is the quantity requested per MONTH? _____
Does the patient require a greater quantity for the treatment of a larger surface area? ❑ **Yes** ❑ **No**

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.