



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 <small>(required)</small>			Provider Information <small>(required)</small>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information <small>(required)</small>			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information <small>(required)</small>																						
<p>Select the diagnosis below:</p> <input type="checkbox"/> Atopic dermatitis <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____																						
<p>Clinical information:</p> <p>Is the affected area sensitive (i.e., face, axillae, groin)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please specify affected area that drug is being prescribed for: _____</p>																						
<p>Select the medications the patient has a failure, contraindication, or intolerance to:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top; padding: 2px;"><input type="checkbox"/> Alclometasone</td> <td style="width: 50%; vertical-align: top; padding: 2px;"><input type="checkbox"/> Fluocinonide</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Amcinonide</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Flurandrenolide</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Augmented betamethasone</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Fluticasone</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Betamethasone</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Halog</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Calcipotriene-betamethasone</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Halobetasol</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Clobetasol</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Hydrocortisone</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Clocortolone</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Mometasone</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Desonide</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Pramoxine-HC</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Desoximetasone</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Prednicarbate</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Diflorasone</td> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Triamcinolone</td> </tr> <tr> <td style="vertical-align: top; padding: 2px;"><input type="checkbox"/> Fluocinolone</td> <td></td> </tr> </table> <p><input type="checkbox"/> Other prescription strength topical corticosteroid(s). Please specify: _____</p>	<input type="checkbox"/> Alclometasone	<input type="checkbox"/> Fluocinonide	<input type="checkbox"/> Amcinonide	<input type="checkbox"/> Flurandrenolide	<input type="checkbox"/> Augmented betamethasone	<input type="checkbox"/> Fluticasone	<input type="checkbox"/> Betamethasone	<input type="checkbox"/> Halog	<input type="checkbox"/> Calcipotriene-betamethasone	<input type="checkbox"/> Halobetasol	<input type="checkbox"/> Clobetasol	<input type="checkbox"/> Hydrocortisone	<input type="checkbox"/> Clocortolone	<input type="checkbox"/> Mometasone	<input type="checkbox"/> Desonide	<input type="checkbox"/> Pramoxine-HC	<input type="checkbox"/> Desoximetasone	<input type="checkbox"/> Prednicarbate	<input type="checkbox"/> Diflorasone	<input type="checkbox"/> Triamcinolone	<input type="checkbox"/> Fluocinolone	
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<p>Quantity limit requests:</p> <p>What is the quantity requested per MONTH? _____</p> <p>Does the patient require a greater quantity for the treatment of a larger surface area? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>																						

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.

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