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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) Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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

Clinical Information (required)	
<b>Select the diagnosis below:</b>	
<input type="checkbox"/> Atopic dermatitis	
<input type="checkbox"/> Other diagnosis: _____	ICD-10 Code(s): _____

Select the medications the patient has a failure, contraindication, or intolerance to:		
<input type="checkbox"/> Ala-Cort 1%	<input type="checkbox"/> Desoximetasone	<input type="checkbox"/> Hydrocortisone butyrate
<input type="checkbox"/> Ala-Cort 2.5%	<input type="checkbox"/> Diflorasone	<input type="checkbox"/> Hydrocortisone lotion
<input type="checkbox"/> Ala Scalp	<input type="checkbox"/> Diprolene	<input type="checkbox"/> Hydrocortisone valerate
<input type="checkbox"/> Alclometasone dipropionate	<input type="checkbox"/> Diprolene AF	<input type="checkbox"/> Impoyz
<input type="checkbox"/> Amcinonide	<input type="checkbox"/> Elidel	<input type="checkbox"/> Locoid
<input type="checkbox"/> Apexicon E	<input type="checkbox"/> Elocon	<input type="checkbox"/> Locoid Lipocream
<input type="checkbox"/> Augmented betamethasone dipropionate 0.05%	<input type="checkbox"/> Fluocinolone acetonide	<input type="checkbox"/> Mometasone furoate
<input type="checkbox"/> Betamethasone dipropionate	<input type="checkbox"/> Fluocinolone acetonide body	<input type="checkbox"/> Nolix
<input type="checkbox"/> Betamethasone valerate	<input type="checkbox"/> Fluocinolone acetonide scalp	<input type="checkbox"/> Pandel
<input type="checkbox"/> Clobetasol propionate	<input type="checkbox"/> Fluocinonide 0.05%	<input type="checkbox"/> Prednicarbate
<input type="checkbox"/> Clobetasol propionate emollient	<input type="checkbox"/> Fluocinonide 0.1%	<input type="checkbox"/> Psorcon
<input type="checkbox"/> Clobex	<input type="checkbox"/> Fluocinonide emulsified base	<input type="checkbox"/> Tacrolimus ointment
<input type="checkbox"/> Cordran tape	<input type="checkbox"/> Flurandrenolide	<input type="checkbox"/> Temovate
<input type="checkbox"/> Cutivate	<input type="checkbox"/> Fluticasone propionate	<input type="checkbox"/> Texacort
<input type="checkbox"/> Desonate	<input type="checkbox"/> Halobetasol	<input type="checkbox"/> Topicort
<input type="checkbox"/> Desonide cream	<input type="checkbox"/> Halog	<input type="checkbox"/> Triamcinolone acetonide
<input type="checkbox"/> Desonide lotion	<input type="checkbox"/> Hydrocortisone 1% cream	<input type="checkbox"/> Trianex
<input type="checkbox"/> Desonide ointment	<input type="checkbox"/> Hydrocortisone 1% ointment	<input type="checkbox"/> Triderm
<input type="checkbox"/> Desowen	<input type="checkbox"/> Hydrocortisone 2.5% cream	<input type="checkbox"/> Tridesilon
<input type="checkbox"/> Other generic topical corticosteroid(s). Please specify: _____	<input type="checkbox"/> Hydrocortisone 2.5% ointment	<input type="checkbox"/> Ultravate

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.  
 If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.  
 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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