



## Eucrisa™ Prior Authorization Request Form (Page 1 of 2)

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Member Information <small>(required)</small>	Provider Information <small>(required)</small>
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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>
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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 <small>(required)</small>
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**Select the diagnosis below:**

Mild to moderate atopic dermatitis

Other diagnosis: \_\_\_\_\_ ICD-10 Code(s): \_\_\_\_\_

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

<input type="checkbox"/> Ala-Cort	<input type="checkbox"/> Diflorasone	<input type="checkbox"/> Hydrocortisone butyrate
<input type="checkbox"/> Alclometasone dipropionate	<input type="checkbox"/> Elidel (pimecrolimus) topical cream	<input type="checkbox"/> Hydrocortisone lotion
<input type="checkbox"/> Amcinonide	<input type="checkbox"/> Fluocinolone acetonide	<input type="checkbox"/> Hydrocortisone valerate
<input type="checkbox"/> Apexicon E	<input type="checkbox"/> Fluocinolone acetonide body	<input type="checkbox"/> Mometasone furoate
<input type="checkbox"/> Augmented betamethasone dipropionate	<input type="checkbox"/> Fluocinolone acetonide scalp	<input type="checkbox"/> Nolix
<input type="checkbox"/> Betamethasone dipropionate	<input type="checkbox"/> Fluocinonide	<input type="checkbox"/> Pandel
<input type="checkbox"/> Betamethasone valerate	<input type="checkbox"/> Fluocinonide emulsified base	<input type="checkbox"/> Prednicarbate
<input type="checkbox"/> Clobetasol propionate	<input type="checkbox"/> Flurandrenolide	<input type="checkbox"/> Psorcon
<input type="checkbox"/> Clobetasol propionate emollient	<input type="checkbox"/> Fluticasone propionate	<input type="checkbox"/> Synalar
<input type="checkbox"/> Cloderm	<input type="checkbox"/> Halobetasol	<input type="checkbox"/> Tacrolimus (generic Protopic) topical ointment
<input type="checkbox"/> Cordran tape	<input type="checkbox"/> Halog	<input type="checkbox"/> Topicort
<input type="checkbox"/> Desonate	<input type="checkbox"/> Hydrocortisone 1% cream	<input type="checkbox"/> Triamcinolone acetonide
<input type="checkbox"/> Desonide cream	<input type="checkbox"/> Hydrocortisone 1% ointment	<input type="checkbox"/> Trianex
<input type="checkbox"/> Desonide lotion	<input type="checkbox"/> Hydrocortisone 2.5% cream	<input type="checkbox"/> Triderm
<input type="checkbox"/> Desonide ointment	<input type="checkbox"/> Hydrocortisone 2.5% ointment	<input type="checkbox"/> Tridesilon
<input type="checkbox"/> Desoximetasone		

**Clinical information:**

Select the topical corticosteroid(s) the patient has a history of trial and failure, contraindication, or intolerance to for a minimum of 2 weeks:

Low potency

Medium potency

High potency

Is the affected area sensitive (e.g., face, axillae, groin)?  Yes  No

Is the patient not a candidate for topical corticosteroids?  Yes  No

Is the patient not a candidate for Elidel or tacrolimus therapy (e.g., immunocompromised)?  Yes  No

**Reauthorization:**

**If this is a reauthorization request, answer the following question:**

Is there documentation of positive clinical response to Eucrisa therapy (e.g., reduction in body surface area involvement, reduction in pruritus severity)?  Yes  No



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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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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.