UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

TOPICAL IMMUNOMODULATORS

pimecrolimus (Elidel®) and tacrolimus (Protopic®)

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency/Day:_____

Please fax documentation from progress notes and this form to 855-828-4992

All information to be legible, complete and correct or form will be returned

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INITIAL AUTHORIZATION: 6 weeks

- **Submit all of the following:**
  - Diagnosis
    - If atopic dermatitis, please write the diagnosis code on the face of the prescription
    - If lichen planus or vitiligo, please indicate if the patient has Hepatitis C
  - Strength, quantity and directions for administration
  - Physical location of affected area(s)
  - Documentation (medical notes) of failure on at least one non-calcineurin-inhibiting agent

RE-AUTHORIZATION: 6 months

- Submit updated medical notes indicating improvement while on therapy