





**FAX Completed Form To** 1.833.404.2392

## **Prescriber Help Desk** 1.833.587.2012

Online

covermymeds.com/main/ prior-authorization-forms/

## **Request for Prior Authorization** Crisaborole (Eucrisa)

ACCLIBACY IS IMPORTANT)

	(FLEASE FRINT - ACCURACT IS	IIVIFORTA	.ivi <i>)</i>	
IA Medicaid Member ID #	Patient name			DOB
Patient address				
Provider NPI	Prescriber name			Phone
Prescriber address				Fax
Pharmacy name	Address			Phone
Prescriber must complete all informa	ation above. It must be legible, correc	t, and com	plete or fo	orm will be returned.
Pharmacy NPI	Pharmacy fax	NI	)C 	
precautions, drug interactions, and dermatitis; and 3) Patient has faile documentation of an adequate trial for a minimum of 2 consecutive we topical immunomodulator for a minimum emollients. 7) Quantities will be limit per 30 days. The required trials modulated by modulating contraindicated.  Non-Preferred	ested drug and indication, including use in specific populations; and 2) If sed to respond to good skin care all and therapy failure with one prefer eeks; and 5) Patient has documents mum of 4 weeks; and 6) Patient will ted to 60 grams for use on the face, hay be overridden when documents.	Patient has nd regular red mediu ation of a continue w neck, and	s a diagnoriuse of of one of one of one of one of one of one of the office of the office of the office of one of o	osis of mild to moderate atopic emollients; and 4) Patient has a potency topical corticosteroid trial and therapy failure with a care regimen and regular use of 100 grams for all other areas,
☐ Eucrisa				
Strength	Usage Instructions	Quan	tity	Day's Supply
Diagnosis:				
	good skin care and regular use of came, dosing instructions & duration of		s?   Y	es
Will patient continue with skin care in Yes Emollient to be used:	regimen and regular use of emollient	ts?	_	0
	cy Topical Corticosteroid Trial:			
Preferred Topical Immunomodula Drug name & dose:	ator Trial:	Trial date	es:	
Affected area to be treated:				
	to override trial requirements:			
	to override trial requirements:			

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.