





Fax Completed Form To 1.833.404.2392

Prescriber Help Desk

1.833.587.2012

Online

covermymeds.com/main/

Request for Prior Authorization IMMUNOMODULATORS-TOPICAL

(PLEASE PRINT – ACCURACY IS IMPORTANT)

	(1 22/102 1 1/1/11 7/1000 1/1/10 1/10	prior-audiforization-iornis/		
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 information above. It must be legible, correct, and complete or form will be returned.				
Pharmacy NPI	Pharmacy fax	NDC		

Prior authorization is required for topical immunomodulators. Payment for non-preferred topical immunomodulator products will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent. Payment for pimecrolimus or tacrolimus 0.03% will be considered for non-immunocompromised patients two years of age and older and tacrolimus 0.1% for patients 16 years of age and older when there is an adequate trial and therapy failure with one preferred topical corticosteroid, except on face or groin. If criteria for coverage are met, requests will be approved for one tube per 90 days to ensure appropriate short-term and intermittent utilization of the medication. Quantities will be limited to 30 grams for use on the face, neck, and groin, and 60 grams or 100 grams for all other areas. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred ☐ Tacrolimus Ointme	_	n-Preferred Pimecrolimus		
Strength	Usage Instructions	Quantity	Days Supply	
Preferred Drug Trial 1: Drug Name & Dose			Trial Dates:	
Failure Reason:				
•	an immunocompromised conditio			
Affected area to be tre	ated:			
Medical or contraindication reason to override trial requirements:				
Attach lab results and	other documentation as necessary	<i>1</i> .		
Prescriber signature (Mu	st match prescriber listed above.)	Date of submission		

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 Health and Human Services, that the member continues to be eligible for Medicaid.