

**Request for Prior Authorization  
 TOPICAL CORTICOSTEROIDS**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #				Patient name				DOB			
Patient address											
Provider NPI				Prescriber name				Phone			
Prescriber address								Fax			
Pharmacy name				Address				Phone			
<b>Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.</b>											
Pharmacy NPI				Pharmacy fax				NDC			

**Prior authorization is required for non-preferred topical corticosteroids. Payment will be considered for patients when there is documentation of adequate trials and therapy failures with at least two preferred, chemically distinct, topical corticosteroid agents within the same potency class or a higher potency class in the past 12 months. The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.**

**Drug Name:** \_\_\_\_\_ **Strength:** \_\_\_\_\_ **Dosage Form:** \_\_\_\_\_

**Dosage Instructions:** \_\_\_\_\_ **Quantity:** \_\_\_\_\_ **Days Supply:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

**Preferred Topical Corticosteroid Trial 1:**

**Drug Name & Dose:** \_\_\_\_\_ **Trial Dates:** \_\_\_\_\_

**Failure Reason:** \_\_\_\_\_

**Preferred Topical Corticosteroid Trial 2:**

**Drug Name & Dose:** \_\_\_\_\_ **Trial Dates:** \_\_\_\_\_

**Failure Reason:** \_\_\_\_\_

**Medical or contraindication reason to override trial requirements:** \_\_\_\_\_

**Attach lab results and other documentation as necessary.**

Prescriber signature (Must 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 Human Services, that the member continues to be eligible for Medicaid.