



NC DHB Pharmacy Request for Prior Approval Topical Anti-Inflammatory Medications

Recipient Information

DMA-0030 (v.03)

1. Recipient Last Name: _____ 2. First Name: _____
3. Recipient ID #: _____ 4. Recipient Date of Birth: _____ 5. Recipient Gender: _____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: Health Choice:

Prescriber Information

7. Prescribing Provider #: _____ NPI: or Atypical:

8. Prescriber DEA #: _____

Requester Contact Information

Name: _____ Phone #: _____ Ext: _____

Drug Information

9a. Drug Name: Elidel Protopic 0.03% Protopic 0.1% 9b. Is this request for a Non-Preferred Drug? Yes No

11. Quantity Per 30 Days: _____

12. Length of Therapy (in days): up to 30 60 90 120 180 365 Other: _____

Clinical Information

For Coverage of Elidel

1. For areas OTHER than groin or face: Has the patient failed 2 generic topical corticosteroids in the highest potency class and is the patient greater than 2 years of age? Yes No

2. For groin and face: Has the patient failed 2 topical generic corticosteroids from preferred list in any potency class (see criteria for list) AND is patient greater than 2 years of age? Yes No

3. Does the patient have a documented adverse reaction or contraindication that precludes trial of 2 generic topical corticosteroids from preferred list (see criteria for list)? Yes No

Please list: _____

For Coverage of Protopic 0.03%:

4. Has the recipient tried and failed Elidel? Yes No

5. For areas OTHER than groin or face: Has the patient failed 2 generic topical corticosteroids in the highest potency class and is the patient greater than 2 years of age? Yes No

6. For groin and face: Has the patient failed 2 topical generic corticosteroids from preferred list in any potency class (see criteria for list) AND is patient greater than 2 years of age? Yes No

7. Does the patient have a documented adverse reaction or contraindication that precludes trial of 2 generic topical corticosteroids from preferred list (see criteria for list)? Yes No

Please list: _____

For Coverage of Protopic 0.1%

8. Has the recipient tried and failed Elidel? Yes No

9. For areas OTHER than groin or face: Has the patient failed 2 generic topical corticosteroids in the highest potency class and is the patient greater than 18 years of age? Yes No

10. For groin and face: Has the patient failed 2 topical generic corticosteroids from preferred list in any potency class (see criteria for list) AND is patient greater than 18 years of age? Yes No

11. Does the patient have a documented adverse reaction or contraindication that precludes trial of 2 generic topical corticosteroids from preferred list (see criteria for list)? Yes No

Please list: _____

Signature of Prescriber: _____ Date: _____

*Prescriber Signature Mandatory

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.