



## NC DMA 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.