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CAREFIRST ASO
Elidel Step Therapy

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Elidel Step Therapy.

Patient Name: _____ **Date:** 11/27/2023
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:** _____
NPI#: _____ **Specialty:** _____
Physician Office Telephone: _____
Physician Office Address: _____

Drug Name (select from list of drugs shown)

Elidel (pimecrolimus) Pimecrolimus

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

- | | | | | | |
|-----|---|---|--------------------------|---|--------------------------|
| 1. | Is the requested drug being prescribed for the short-term and non-continuous chronic treatment of mild to moderate atopic dermatitis (eczema)? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 2. | Is the request for continuation of therapy? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 3. | Is the patient 2 years of age or older? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 4. | Has the patient achieved or maintained a clinical response as evidenced by improvement [(e.g., improvement in or resolution of any of the following signs and symptoms: erythema (redness), edema (swelling), xerosis (dry skin), erosions, excoriations (evidence of scratching), oozing and crusting, lichenification (epidermal thickening), OR pruritus (itching)]? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 5. | Has the patient achieved or maintained a clinical response as evidenced by improvement [(e.g., improvement in or resolution of any of the following signs and symptoms: erythema (redness), edema (swelling), xerosis (dry skin), erosions, excoriations (evidence of scratching), oozing and crusting, lichenification (epidermal thickening), OR pruritus (itching)]? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 6. | Is the patient less than 2 years of age? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 7. | Will the requested drug be used on sensitive skin areas (e.g., face, genitals, or skin folds)? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 8. | Has the patient experienced an inadequate treatment response, intolerance, or contraindication to at least one first line therapy agent (e.g., medium or higher potency topical corticosteroid)? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 9. | Is the requested drug being prescribed for psoriasis on the face, genitals, or skin folds? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 10. | Is the request for continuation of therapy? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 11. | Has the patient achieved or maintained a positive clinical response as evidenced by improvement (e.g., clear, or almost clear outcome, patient satisfaction, etc.)? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 12. | Is the requested drug being prescribed for vitiligo on the head or neck? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |



13. Is the request for continuation of therapy? Y ☐ N ☐
14. Has the patient achieved or maintained a positive clinical response as evidenced by improvement (e.g., meaningful repigmentation)? Y ☐ N ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date

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