CAREFIRST MD
Protopic 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 855-582-2038 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Protopic Step Therapy.

Patient Information

Patient Name:

Patient Phone: ☐☐☐-☐☐☐-☐☐☐☐

Patient ID:

Patient Group:

Patient DOB: ☐☐/☐☐/☐☐☐☐

Physician Information

Physician Name

Physician Phone: ☐☐☐-☐☐☐-☐☐☐☐

Physician Fax: ☐☐☐-☐☐☐-☐☐☐☐

Physician Addr.:

City, St, Zip:

Drug Name (select from list of drugs shown)

Tacrolimus 0.1% Ointment Tacrolimus 0.03% Ointment

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 request for tacrolimus 0.1 percent ointment?	**Y** ☐	**N** ☐
2.	Is the patient 16 years of age or older?	**Y** ☐	**N** ☐
3.	Is the requested drug being prescribed for the short-term and non-continuous chronic treatment of moderate to severe atopic dermatitis (eczema)?	**Y** ☐	**N** ☐
4.	Is the request for continuation of therapy?	**Y** ☐	**N** ☐
5.	Is the requested drug being prescribed for the short-term and non-continuous chronic treatment of moderate to severe atopic dermatitis (eczema)?	**Y** ☐	**N** ☐
6.	Is the request for continuation of therapy?	**Y** ☐	**N** ☐
7.	Is the patient 2 year of age or older?	**Y** ☐	**N** ☐
8.	Has the patient achieved or maintained a positive 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** ☐	**N** ☐
9.	Has the patient achieved or maintained a positive 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** ☐	**N** ☐
10.	Is the patient less than 2 years of age?	**Y** ☐	**N** ☐
11.	Will the requested drug be used on sensitive skin areas (e.g., face, genitals, or skin folds)?	**Y** ☐	**N** ☐

12.	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** ☐	**N** ☐
13.	Is the requested drug being prescribed for psoriasis on the face, genitals, or skin folds?	**Y** ☐	**N** ☐
14.	Is the request for continuation of therapy?	**Y** ☐	**N** ☐
15.	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** ☐	**N** ☐
16.	Is the requested drug being prescribed for vitiligo on the head or neck?	**Y** ☐	**N** ☐
17.	Is the request for continuation of therapy?	**Y** ☐	**N** ☐
18.	Has the patient achieved or maintained a positive clinical response as evidenced by improvement (e.g., meaningful regimentation)?	**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