BlueCross BlueShield Federal Employee Program

EUCRISA
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

Eucrisa (crisaborole)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

1. Does the patient have a diagnosis of atopic dermatitis or eczema? ❑Yes ❑No
2. Will Eucrisa be used in combination with another Topical Prior Authorization (PA) medication for atopic dermatitis (eczema)? ❑Yes* ❑No
   ***If YES,** please specify the medication: _____
3. Has the patient been on Eucrisa continuously for the last **2 months**, excluding samples? ***Please select answer below:***

❑ **NO –** this is **INITIATION** of therapy, please answer the following questions:

a. Does the patient have a diagnosis of mild to moderate atopic dermatitis (eczema)? ❑Yes ❑No

b. Does the patient have a documented baseline evaluation of their condition using one of the following scoring tools: Investigator's Static Global Assessment (ISGA) score, Eczema Area and Severity Index (EASI), Patient-Oriented Eczema Measure (POEM), or Scoring Atopic Dermatitis (SCORAD) index? ❑Yes ❑No

c. **Age 3 months to less than 2 years**: Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a topical corticosteroid? ❑Yes ❑No

d. **Age 2 to 17**: Please answer the following questions:

i. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a topical corticosteroid? ❑Yes ❑No

ii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a topical calcineurin inhibitor such as Elidel (pimecrolimus) or Protopic (tacrolimus)? ❑Yes ❑No

e. **Age 18 or older**: Please answer the following questions:

i. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a high potency topical corticosteroid such as Amcinonide, Fluocinonide, or Halcinonide? ❑Yes ❑No

ii. Does the patient have lesions on their face, neck, or skin folds? ❑Yes* ❑No
   ***If YES**, does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a low to medium potency topical corticosteroid? ❑Yes ❑No

iii. Does the patient have an intolerance or contraindication or have they had an inadequate treatment response to a topical calcineurin inhibitor such as Elidel (pimecrolimus) or Protopic (tacrolimus)? ❑Yes ❑No

f. Will the patient need more than 4 tubes for a 4 month supply (*1 tube = 60g or 100g*)? ❑Yes* ❑No
   ***If YES**, please specify the requested quantity: _____ tubes for a 4 month supply

❑ **YES –** this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

a. Which scoring tool was used to obtain the patient's baseline status? ***Select scoring tool and answer the following question:***

❑Eczema Area and Severity Index (EASI)
   i. Does the patient have a documented improvement from baseline by at least 75%? ❑Yes ❑No

❑Investigator's Static Global Assessment (ISGA) score
   i. Does the patient have a documented improvement from baseline by at least 2 points? ❑Yes ❑No

❑Patient-Oriented Eczema Measure (POEM)
   i. Does the patient have a documented improvement from baseline by at least 3 points? ❑Yes ❑No

❑**Sc**oring Atopic Dermatitis (SCORAD) index
   i. Does the patient have a documented decrease from baseline by at least 50%? ❑Yes ❑No

❑None of the above

b. Will the patient need more than 3 tubes every 90 days (*1 tube = 60g or 100g*)? ❑Yes* ❑No
   ***If YES**, please specify the requested quantity: _____ tubes every 90 days

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer. Eucrisa – FEP MD Fax Form Revised 1/24/2025