Prior Authorization Form

Elidel

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Elidel.

Drug Name (select from list of drugs shown)
Elidel (pimecrolimus) Pimecrolimus

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is the requested drug being prescribed for mild to moderate atopic dermatitis (eczema)?	Y N
[If no, then skip to question 5.]	
2. Will the requested drug be used on sensitive skin areas (e.g. face, genitals, or skin folds)?	Y N
[If yes, then no further questions.]	
3. 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
[If yes, then no further questions.]	

4.	Is the patient less than 2 years of age?	Y N
	[No further questions.]	
5.	Is the requested drug being prescribed for psoriasis on the face, genitals, or skin folds OR vitiligo on the head or neck?	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