

**Neighborhood Health Plan of Rhode Island
Prior Authorization Form
Elidel® (Pimecrolimus) and Protopic® (Tacrolimus)**

Date of Request: _____

If approval criteria are met, Neighborhood Health Plan of Rhode Island will authorize coverage of Elidel® (Pimecrolimus) or Protopic® (Tacrolimus). Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance. Please fax completed form to NHPRI at (401) 427-6754.

Please complete the following information:

Member Name: (required)	Member ID Number: (required)
Member Date of Birth: (required) / /	Member Sex: M F (Circle One)

Prescriber Name: (required)	Contact Person at Office:
Office Phone number: (required) () -	Office Fax Number: (required) () -

Please be advised that the FDA has issued the following warning regarding the use of these topical immunomodulators:

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| <ul style="list-style-type: none"> • Use Elidel and Protopic only as second-line agents for short-term and intermittent treatment of atopic dermatitis (eczema) in patients unresponsive to, or intolerant of other treatments. • Avoid use of Elidel and Protopic in children younger than 2 years of age. The effect of Elidel and Protopic on the developing immune system in infants and children is not known. In clinical studies, infants and children younger than 2 years old treated with Elidel had a higher rate of upper respiratory infections than did those treated with placebo cream. • Use Elidel and Protopic only for short periods of time, not continuously. The long term safety of Elidel and Protopic are unknown. • Children and adults with a weakened or compromised immune system should not use Elidel or Protopic. • Use the minimum amount of Elidel or Protopic needed to control the patient's symptoms. In animals, increasing the dose resulted in higher rates of cancer. |
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In accordance with FDA guidance, NHPRI requires that ALL patients naïve to treatment with topical immunomodulators demonstrate prior claims evidence (within the past 90 days) of a topical corticosteroid. All topical corticosteroids will satisfy this contingent therapy requirement. A list of suggested products is provided.

<u>Low Potency</u>	<u>Medium Potency</u>	<u>High Potency</u>	<u>Very High Potency</u>
Fluocinolone 0.01%	Betamethasone Diprionate 0.05%	Betamethasone Diprionate cream 0.05%	Augmented Betamethasone Diprionate ointment 0.05%
Desonide 0.05%	Betamethasone Valerate cream 0.1%	Augmented Betamethasone Diprionate cream 0.05%	Clobetasol 0.05%
Hydrocortisone 1%, 2.5%	Desoximetasone 0.05%	Betamethasone Valerate ointment 0.1%	Diflorasone 0.05%
	Fluocinolone 0.025%	Desoximetasone 0.05%, 0.25%	
	Triamcinolone 0.025%, 0.1%	Fluocinonide 0.05%	
		Triamcinolone 0.5%	

ASSESSMENT OF BENEFIT NEED:

	YES	NO
1. Has patient attempted a trial of a topical corticosteroid? If yes, please specify which product was tried_____.	<input type="checkbox"/>	<input type="checkbox"/>
2. Is a trial of a topical corticosteroid considered inappropriate for this patient? If yes, please give details_____.	<input type="checkbox"/>	<input type="checkbox"/>

Which product are you requesting? Elidel Protopic

How long is the treatment with Elidel or Protopic? _____

All information provided on this form is accurate as of this date.
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Provider Signature: _____ **Date:** _____