



Request for Prior Authorization
Select Topical Agents

FAX Completed Form To
1 (877) 733-3195
Provider Help Desk
1 (844) 236-1464



(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC. Includes a warning: Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

Prior authorization (PA) is required for select topical agents. Payment for a non-preferred agent will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria are met:

- 1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2. Patient has a diagnosis of plaque psoriasis with involvement estimated to affect <= 20% of the body surface area; and
3. Patient has a diagnosis of seborrheic dermatitis; and
4. Patient has a diagnosis of mild to moderate atopic dermatitis; and

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Non-Preferred

- Vtama
Zoryve

Strength

Usage Instructions

Quantity

Days Supply

Diagnosis:

Plaque Psoriasis

Preferred Medium to High Potency Topical Corticosteroid Trial:

Drug name & dose: Trial dates:

Failure reason:

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Preferred Topical Vitamin D Analog Trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Is affected area estimated to affect \leq 20% body surface area? Yes No

Seborrheic Dermatitis

Preferred Topical Corticosteroid Trial: Scalp Nonscalp

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Preferred Topical Antifungal Trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Mild to moderate atopic dermatitis

Preferred Medium to High Potency Topical Corticosteroid Trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Preferred Topical Immunomodulator Trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Has patient failed to respond to good skin care and regular use of emollients? Yes No

Medical or contraindication reason to override trial requirements: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.