

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Elidel[®] (pimecrolimus)
Protopic[®] (tacrolimus)
**Complete form in its entirety and fax to:
 Prior Authorization of Benefits (PAB) Center at (866) 807- 6241**
1. PATIENT INFORMATION
2. PHYSICIAN INFORMATION

Patient Name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient Phone #: _____	Physician Specialty: _____
Patient Email Address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician Email Address: _____

3. MEDICATION
4. STRENGTH
5. DIRECTIONS
6. QUANTITY PER 30 DAYS

<input type="checkbox"/> Elidel (pimecrolimus)	<input type="checkbox"/> 1%	_____	_____
<input type="checkbox"/> Protopic (tacrolimus)	<input type="checkbox"/> 0.03% <input type="checkbox"/> 0.1%		

7. DIAGNOSIS: _____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY
NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient is equal to or greater than 2 years of age
<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient has had a trial of one topical prescription corticosteroid within the previous 120 days

9. PHYSICIAN SIGNATURE

_____ Prescriber or Authorized Signature	_____ Date
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Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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