SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Immunomodulators Atopic Dermatitis

Drug Requested: (check box be low that applies)

PREFERRED		
❑ **Adbry™** (tralokinumab)	❑ **Dupixent®** (dupilumab) (QL, AG) **(Refer to Dupixent PA form)**	❑ **Elidel®** (pimecrolimus)
❑ **Eucrisa™** (crisaborole)	❑ **tacrolimus** (generic Protopic®)	
Non-Preferred		
❑ **Cibinqo™** (abrocitinib) **(Refer to Cibinqo PA form)**	❑ **Opzelura™** (ruxolitinib) (QL, AG) **(Refer to Opzelura PA form)**	❑ **Pimecrolimus** (generic Elidel®)
❑ **Protopic®** (tacrolimus)		

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

(Continued on next page)

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Length of Authorization: 1 year

- ❑ Member must have an FDA-approved diagnosis of **Atopic Dermatitis**
  - ❑ **Adbry™**: moderate to severe for ages ≥12 years
  - ❑ **Elidel®**: mild to moderate for ages ≥ 2 years
  - ❑ **Eucrisa™**: mild to moderate for ages equal to or > 3 months
  - ❑ **Protopic®** 0.03%: moderate to severe for ages ≥ 2 years
  - ❑ **Protopic®** 0.1%: moderate to severe for ages ≥ 16 years
- ❑ For **Elidel®** or **tacrolimus**:
  - ❑ Prior documented trial and failure of 8 weeks (or contraindication) to one (1) medium to high potency (e.g., mometasone, triamcinolone) topical corticosteroid
- ❑ For **Eucrisa™** or **Adbry®**:
  - ❑ Prior documented trial and failure of 30 days (or contraindication) to one (1) medium to high potency (e.g., mometasone, triamcinolone) topical corticosteroid

    OR
  - ❑ Prior documented trial and failure of 30 days (or contraindication) to one (1) topical calcineurin inhibitor (tacrolimus or pimecrolimus)
- ❑ For **Protopic® and pimecrolimus**:
  - ❑ Failure to topical medium to high potency corticosteroids (i.e., mometasone, triamcinolone)

    AND
  - ❑ Failure to **Elidel®** and tacrolimus (generic)

*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****