# 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) | ❑ **pimecrolimus** (AG) | ❑ **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) | ❑ **Zoryve® cream 0.15%** | ❑ **Zoryve® foam 0.3%** |

**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:** _____

**NPI #:** _____

**DRUG INFORMATION:** Authorization may be delayed if incomplete.

**Drug Name/Form/Strength:** _____

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

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

**Weight (if applicable):** _____ **Date weight obtained:** _____

**(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
  - ❑ **Zoryve cream** 0.15%: mild to moderate for ages ≥ 6 years
- ❑ For **Elidel®**, **pimecrolimus (AG)** 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)
  - ❑ Failure to **Elidel®** or **pimecrolimus (AG)** and **tacrolimus** (generic)
- ❑ For **Zorvye cream 0.15%**:
  - ❑ Failure to **TWO** PDL preferred products: **Elidel®, pimecrolimus (AG), tacrolimus, Eucrisa™**
- ❑ For **Zoryve foam 0.3%:**
  - ❑ Member is 9 years of age or older and has a diagnosis of seborrheic dermatitis.

*****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.****



**REVISED/UPDATED/REFORMATTED:** ~~6/29/2017; 8/29/2017; 8/18/2018; 12/11/2018; 2/27/2019; 6/13/2019; 9/7/2019; 12/22/2020;12/09/2021;1/10/2022; 6/29/2022; 7/14/2022; 12/27/2022; 9/14/2023; 12/21/2023, 12/3/2024,~~ **12/12/2024**