UnitedHealthcare Community Plan

Atopic Dermatitis Agents: Eucrisa® (crisaborole) - Washington
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Apple Health Preferred Drug list: https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

UnitedHealthcare Community Plan

Atopic Dermatitis Agents: Eucrisa® (crisaborole) - Washington
Prior Authorization Request Form

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   If yes, is there documentation of disease stability or improvement from baseline? ☐ Yes ☐ No

2. Indicate patient's diagnosis:
   ☐ Atopic dermatitis
   ☐ Other. Specify: _____

3. Does the patient have a history of trial and failure of at least TWO preferred topical corticosteroids (medium or higher potency) for daily treatment for at least minimum 28-days within the previous 6 months (check all that apply)?
   ☐ Yes. Specify which products: _____
   ☐ No
   ☐ Topical steroids contraindicated.
      ☐ Treatment of sensitive areas (face, anogenital, skin folds) not responding to low potency desonide or hydrocortisone
      ☐ History of steroid induced atrophy
      ☐ Long-term uninterrupted use
      ☐ Other. Explain: _____
   ☐ None of the above

4. Has the patient tried and failed at least ONE topical calcineurin inhibitors (i.e., pimecrolimus, tacrolimus) for at least 28-days (check all that apply)?
   ☐ Yes
   ☐ No
   ☐ Topical calcineurin inhibitors (i.e., pimecrolimus, tacrolimus) are contraindicated.
      ☐ Patient is less than 2 years old.
      ☐ Other. Explain: _____
   ☐ None of the above

Baseline evaluation of the disease state (atopic dermatitis), including severity of symptoms and chart notes are required with this request

Prescriber signature	Prescriber specialty	Date