Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: ______________________________ Strength: _______________ Directions: ____

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: _____________________

Physician Fax#: _____________________ Pharmacy Name: ____________________________ Pharmacy Phone: __________________

Horizon NJ Health

Pimecrolimus (Elidel), Tacrolimus (Protopic) and Crisaborole (Eucrisa) – Medical Necessity Request

Complete this page for Initial Requests

1. What is/are the affected area(s)? ____

2. For Pimecrolimus and Tacrolimus requests: Is the member immunocompromised? **Yes or No**
   - If Yes, please provide the diagnosis or treatment that causes the member to be immunocompromised.
     ____

3. Has the member tried and failed a topical corticosteroid (e.g., OTC hydrocortisone, hydrocortisone valerate, betamethasone, fluocinolone, mometasone, fluticasone, desoximetasone)? **Yes or No**
   - If No, can the patient try a topical corticosteroid instead? **Yes or No**
     - If Yes, please call the prescription in to the pharmacy.
     - If No, please provide the clinical reason(s) why the member cannot try a topical corticosteroid first.
       ____

4. For Pimecrolimus and Eucrisa requests: Can patient try Tacrolimus Ointment? **Yes or No**
   - If Yes, please notify the pharmacy of the change and proceed to next section.
   - If No, please provide the clinical reason(s) why the member cannot try Tacrolimus Ointment.
     ____

Diagnosis Information (please indicate diagnosis):

□ Atopic Dermatitis/Eczema
□ Dermatitis
- What type of dermatitis does the member have?
  - □ Atopic
  - □ Other: ____

□ Psoriasis
- What type of psoriasis does the member have?
  - □ Facial
  - □ Inverse/Intertriginous
  - □ Other: ____

□ Graft-Versus-Host Disease (GVHD)
□ Other: ___________________________________

Continued on p. 2

Physician office's signature* _________________________________ **Print Name** _______________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: ______________________________ Member ID: ________________ Member DOB: ________________

Drug Name: _____________________________ Strength: _______________ Directions: ______________________________________

Physician Name: __________________________ Physician Phone #: _________________________ Specialty: _____________________

Physician Fax#: _____________________ Pharmacy Name: ____________________________Pharmacy Phone: __________________

Complete this section only for members less than 2 years of age (Pimecrolimus or Tacrolimus requests) or less than 3 months of age (Eucrisa requests):

1. Is the condition poorly controlled? **Yes or No**
2. Is the condition persistent? **Yes or No**
3. Is the member being managed by an Allergist or Dermatologist? **Yes or No**

Physician office's signature*__________________________________ Print Name________________________________

***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: ____________________________ Member ID: _______________ Member DOB: _______________

Drug Name: ____________________________ Strength: ______________ Directions: ____________________________________

Physician Name: _________________________ Physician Phone #: ________________________ Specialty: ____________________

Physician Fax#: ____________________ Pharmacy Name: ___________________________ Pharmacy Phone: _________________

Horizon NJ Health

Pimecrolimus (Elidel), Tacrolimus (Protopic) and Crisaborole (Eucrisa) – Medical Necessity Request

Complete this page for Subsequent Requests

Diagnosis Information (please indicate diagnosis):

□ Atopic Dermatitis/Eczema
□ Dermatitis
- What type of dermatitis does the member have?
  □ Atopic
  □ Other: ____

□ Psoriasis
- What type of psoriasis does the member have?
  □ Facial
  □ Inverse/Intertriginous
  □ Other: ____

□ Graft-Versus-Host Disease (GVHD)
□ Other: ____________________________________

Physician office's signature*________________________________ Print Name_______________________________
***Form must be completed and signed by physician or licensed representative from the physician's office**