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

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

2. For Elidel and Tacrolimus (Protopic): 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 of Elidel/Protopic? **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 Elidel and Eucrisa requests: Can patient try Tacrolimus Ointment? **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 Tacrolimus Ointment.
     _____

Diagnosis Information (please indicate diagnosis and answer related questions):

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

□ Psoriasis
□ Inverse/Intertriginous Psoriasis
□ Facial Psoriasis
□ Other: _____

Complete this section only for members less than 2 years of age:

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**