

Iowa Department of Human Services

FAX Completed Form To 1 (800) 574-2515

Provider Help Desk 1 (877) 776-1567

Request for Prior Authorization Crisaborole (Eucrisa)

(PLEASE PRINT - ACCURACY IS IMPORTANT) IA Medicaid Member ID # Patient name DOB Patient address Provider NPI Prescriber name Phone Prescriber address Fax Pharmacy name Address Phone Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned. Pharmacv NPI Pharmacv fax NDC Prior authorization (PA) is required for Eucrisa (crisaborole). Payment will be considered when patient has an FDA approved or compendia indication for the requested drug when the following criteria are met: 1) Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warning and precautions, drug interactions, and use in specific populations; and 2) Patient has a diagnosis of mild to moderate atopic dermatitis; and 3) Patient has failed to respond to good skin care and regular use of emollients; and 4) Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; and 5) Patient has documentation of a previous trial and therapy failure with a

topical immunomodulator for a minimum of 4 weeks; and 6) Patient will continue with skin care regimen and regular use of emollients. 7) Quantities will be limited to 60 grams for use on the face, neck, and groin and 100 grams for all other areas, per 30 days. The required trials may be overridden when documented evidence is provided that use of these agents

Non-Preferred

☐ Fucrisa

would be medically contraindicated.

Strength	Usage Instructions	Quar	ntity	Day's Supply
Diagnosis:				
	to good skin care and regular use uct name, dosing instructions & dura			
	care regimen and regular use of emo			
Preferred Medium to High Po	tency Topical Corticosteroid Trial	:		
_			tes:	
Preferred Topical Immunomo				
Drug name & dose: Trial dates:				
Medical or contraindication rea	son to override trial requirements:			
	documentation as necessary.			
Prescriber signature (Must match prescriber listed above.)			Date of submission	

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.