



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
 Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
 Elidel Step Therapy (Medicare Prior Auth)**

This fax machine is located in a secure location as required by HIPAA regulations.
 Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.
 Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.
 When conditions are met, we will authorize the coverage of Elidel Step Therapy (Medicare Prior Auth).

Drug Name (select from list of drugs shown)
 Elidel (pimecrolimus)

Patient Information

Patient Name: _____
 Patient ID: _____
 Patient Group No.: _____
 Patient DOB: _____

Prescribing Physician

Physician Name: _____
 Physician Phone: _____
 Physician Fax: _____
 Physician Address: _____
 City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each applicable question.

- | | | |
|---|---|---|
| 1. Does the patient have the diagnosis of mild to moderate atopic dermatitis (eczema)? | Y | N |
| 2. Has the patient been advised that Elidel should only be used to treat the immediate problem and then should be stopped when the condition improves? | Y | N |
| 3. Is the patient 2 years of age or older?
[If the answer to this question is no, then no further questions required.] | Y | N |
| 4. Is the patient a candidate for medium to high potency corticosteroid therapy?
[If the answer to this question is no, then no further questions required.] | Y | N |
| 5. Has the patient tried and had an inadequate response to at least two medium or higher potency topical corticosteroids?
[If the answer to this question is yes, then no further questions required.] | Y | N |
| 6. Does the patient have a contraindication or allergy to all corticosteroids (not the vehicles)? | Y | N |

Comments: _____



**Arkansas
BlueCross BlueShield**
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I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date