



Prior Authorization Form

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

Drug Name (select from list of drugs shown)

Protopic (tacrolimus)

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. Is the patient 2 years of age or older? | Y | N |
| 2. Does the patient have the diagnosis of moderate to severe atopic dermatitis (eczema)? | Y | N |
| 3. 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 skip to question 6.] | Y | N |
| 4. Is the patient a candidate for medium to high potency corticosteroid therapy?
[If the answer to this question is no, then skip to question 6.] | Y | N |
| 5. Does the patient have a contraindication or allergy to all topical corticosteroids (not the vehicle)? | Y | N |
| 6. Is the prescription for Protopic 0.1% Ointment?
[If the answer to this question is no, may skip to question 8.] | Y | N |
| 7. Is the patient 16 years of age or older? | Y | N |
| 8. Has the patient been advised that Protopic should only be used to treat the immediate problem and then should be stopped when the condition improves? | Y | N |



**Arkansas
BlueCross BlueShield**
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Comments:

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

Prescriber (Or Authorized) Signature and Date