

**Neighborhood Health Plan of Rhode Island
Prior Authorization Form
Elidel® (Pimecrolimus) and Protopic® (Tacrolimus)**

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If approval criteria are met, Neighborhood Health Plan of Rhode Island will authorize coverage of Elidel® (Pimecrolimus) or Protopic® (Tacrolimus). Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance. **Please fax completed form to NHPRI at 866-423-0945.**

Please complete the following information:

Member Name: (required)	Member ID Number: (required)
Member Date of Birth: (required) / /	Member Sex: M F (Circle One)
Prescriber Name: (required)	Contact Person at Office:
Office Phone number: (required) () -	Office Fax Number: (required) () -

Drug Requested _____ **Directions** _____

Please be advised that the FDA has issued the following warning regarding the use of these topical immunomodulators

- Use Elidel and Protopic only as second-line agents for short-term and intermittent treatment of atopic dermatitis (eczema) in patients unresponsive to, or intolerant of other treatments.
- Avoid use of Elidel and Protopic in children younger than 2 years of age. The effect of Elidel and Protopic on the developing immune system in infants and children is not known. In clinical studies, infants and children younger than 2 years old treated with Elidel had a higher rate of upper respiratory infections than did those treated with placebo cream.
- Use Elidel and Protopic only for short periods of time, not continuously. The long term safety of Elidel and Protopic are unknown.
- Children and adults with a weakened or compromised immune system should not use Elidel or Protopic.
- Use the minimum amount of Elidel or Protopic needed to control the patient's symptoms. In animals, increasing the dose resulted in higher rates of cancer.

In accordance with FDA guidance, NHPRI requires that ALL patients naïve to treatment with topical immunomodulators demonstrate prior claims evidence (within the past 90 days) of a topical corticosteroid. All topical corticosteroids will satisfy this contingent therapy requirement. A list of suggested products is provided.

<u>Low Potency</u> Fluocinolone 0.01% Desonide 0.05%	<u>Medium Potency</u> Betamethasone Diprionate 0.05% Betamethasone Valerate cr 0.1%	<u>High Potency</u> Betamethasone Diprionate cr 0.05% Augmented Betamethasone Diprionate cream 0.05% Betamethasone Valerate oint 0.1% Desoximetasone 0.05%, 0.25% Fluocinonide 0.05% Triamcinolone 0.5%	<u>Very High Potency</u> Clobetasol 0.05% Augmented Betamethasone Diprionate oint 0.05% Diflorasone 0.05%
Hydrocortisone 1%, 2.5%	Desoximetasone 0.05% Fluocinolone 0.025% Triamcinolone 0.025%, 0.1%		

Please check all that apply:

- Patient has failed therapy with topical corticosteroids (please list all failed drugs)

- Use of topical steroids is inappropriate for this patient (please provide specific information)

Signature _____ **NPI** _____ **Date** _____

Please fax completed form to NHPRI at 866-423-0945