

ELIDEL/PROTOPIC PRIOR AUTHORIZATION REQUEST

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date: _____			
SECTION A - PATIENT INFORMATION			
First Name:		Last Name:	
Address:		Member ID:	
City:	State:	Zip:	
Phone:	DOB:	Allergies:	
Primary Insurance:	Policy #:	Group #:	
Is the requested medication NEW <input type="checkbox"/> or a CONTINUATION of THERAPY <input type="checkbox"/> ? If so, start date: _____			
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Is the patient residing in a LTC facility? <input type="checkbox"/> Yes <input type="checkbox"/> No			
SECTION B - PHYSICIAN INFORMATION			
First Name:		Last Name: _____ M.D./D.O.	
Address:		City:	State: _____ Zip: _____
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax Attention to: _____			
Medication to be Administered: <input type="checkbox"/> Physician's Office <input type="checkbox"/> Patient's Home <input type="checkbox"/> LTC Facility <input type="checkbox"/> Other			
SECTION C - MEDICAL INFORMATION			
Medication:		Strength:	Dosing frequency:
Directions for use: _____			
Diagnosis (Please be specific & provide as much information as possible):			ICD-10 CODE:
Is the requested medication intended to be applied topically to the face, axillae (armpit), or genital area for this patient? Yes _____ No _____			
Has the patient been previously treated with at least <u>two</u> topical corticosteroids which resulted in an inadequate response? Yes _____ No _____			
List medications tried and dates of therapy: _____			
Did the patient experience an intolerance / adverse reactions, or has a documented contraindication, to treatment with at least <u>two</u> topical corticosteroids? Yes _____ No _____			
List medications tried and adverse reaction/intolerance: _____			

Physician Signature: _____ **Date:** _____

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