UnitedHealthcare Community Plan

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:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW □ or a CONTINUATION of THERAPY□? If so, start date:_____

Is this patient currently hospitalized? □Yes □No

Is the patient residing in a LTC facility? □Yes □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: □Physician's Office □Patient's Home □LTC Facility □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:** _____