

Request for Prior Authorization Select Topical Agents

FAX Completed Form To
1 (800) 574-2515
Provider Help Desk
1 (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID # 	Patient name	DOB
Patient address		
Provider NPI 	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI 	Pharmacy fax	NDC

Prior authorization (PA) is required for select topical agents. Payment for a non-preferred agent will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following criteria are met:

1. Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations (note, only FDA-approved indications for each drug and specific dosage form will be considered); and
2. Patient has a diagnosis of plaque psoriasis with total overall involvement on scalp and non-scalp areas $\leq 25\%$ of the body surface area (BSA) at baseline. Total non-scalp BSA should not exceed 20%; and
 - a. Patient has documentation of an adequate trial and therapy failure of combination therapy with a preferred medium to high potency topical corticosteroid and a preferred topical vitamin D analog for a minimum of 4 consecutive weeks; or
3. Patient has a diagnosis of seborrheic dermatitis; and
 - a. Patient has documentation of an adequate trial and therapy failure of combination therapy with a preferred topical corticosteroid (scalp-medium to high potency or nonscalp-low potency) and preferred topical antifungal for a minimum of 4 consecutive weeks; or
4. Patient has a diagnosis of mild to moderate atopic dermatitis; and
 - a. Patient has failed to respond to good skin care and regular use of emollients; and
 - b. Patient has documentation of an adequate trial and therapy failure with one preferred medium to high potency topical corticosteroid for a minimum of 2 consecutive weeks; or
 - c. Patient has documentation of an adequate trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks.

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Preferred **Non-Preferred**

☐ Vtama ☐ Zoryve

Strength

Usage Instructions

Quantity

Day's Supply

Diagnosis: _____

☐ **Plaque Psoriasis**

Preferred Medium to High Potency Topical Corticosteroid Trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

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Preferred Topical Vitamin D Analog Trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Is total overall BSA \leq 25%? ☐ Yes ☐ No

Is total non-scalp BSA \leq 20%? ☐ Yes ☐ No

☐ **Seborrheic Dermatitis**

Preferred Topical Corticosteroid Trial: ☐ Scalp ☐ Nonscalp

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Preferred Topical Antifungal Trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

☐ **Mild to moderate atopic dermatitis**

Preferred Medium to High Potency Topical Corticosteroid Trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Preferred Topical Immunomodulator Trial:

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Has patient failed to respond to good skin care and regular use of emollients? ☐ Yes ☐ No

Medical or contraindication reason to override trial requirements: _____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission
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IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*