

Iowa Department of Human Services

FAX Completed Form To 1 (800) 574-2515

Provider Help Desk 1 (877) 776-1567

Request for Prior Authorization IMMUNOMODULATORS-TOPICAL

(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 informa	ation above. It must be legible, correct, and co	nplete or form will be returned.
Pharmacy NPI		IDC
Prior authorization is requir	ed for topical immunomodulators.	Payment for non-preferred topical
will be considered for non-immu 0.1% for patients 16 years of age topical corticosteroid, except on tube per 90 days to ensure approlimited to 30 grams for use on	rred agent. Payment for pimecrolimus (E mocompromised patients two years of age and older when there is an adequate trial face or groin. If criteria for coverage are opriate short-term and intermittent utilization the face, neck, and groin, and 60 grams on when documented evidence is provide	e and older and tacrolimus (Protopic®) and therapy failure with one preferred net, requests will be approved for one on of the medication. Quantities will be or 100 grams for all other areas. The
	Non-Preferred S Ointment Pimecrolimus Usage Instructions Quantity	☐ Protopic Days Supply
☐ Elidel ☐ Tacrolimus	S Ointment Pimecrolimus	
Strength Diagnosis:	S Ointment Pimecrolimus	Days Supply
Strength Diagnosis: Preferred Drug Trial 1: Drug Na Failure Reason Does the patient have an immur	S Ointment Pimecrolimus Usage Instructions Quantity	Days Supply Trial Dates:
Strength Diagnosis: Preferred Drug Trial 1: Drug Na Failure Reason Does the patient have an immur If yes, diagnosis:	S Ointment Pimecrolimus Usage Instructions Quantity ame& Dose nocompromised condition? Yes No	Days Supply Trial Dates:
Strength Diagnosis: Preferred Drug Trial 1: Drug Na Failure Reason Does the patient have an immur If yes, diagnosis: Affected area to be treated:	Pimecrolimus Usage Instructions Quantity ame& Dose nocompromised condition? Yes No	Days Supply Trial Dates:
Strength Diagnosis: Preferred Drug Trial 1: Drug Na Failure Reason Does the patient have an immur If yes, diagnosis: Affected area to be treated:	Usage Instructions Quantity ame& Dose nocompromised condition? Yes No	Days Supply Trial Dates:

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 Human Services, that the member continues to be eligible for Medicaid.