pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

IMMUNOMODULATORS, ATOPIC DERMATITIS PRIOR AUTHORIZATION FORM *(form effective 1/8/2024)*

Prior authorization guidelines for **Immunomodulators, Atopic Dermatitis** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:	
Directions:		Quantity:	Refills:
Diagnosis (*submit documentation*):		Diagnosis code (*required*):	

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

1. For a non-preferred topical calcineurin inhibitor*:*
   ☐Tried and failed or has a contraindication or an intolerance to the preferred topical calcineurin inhibitors *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

2. For a topical JAK inhibitor (eg, Opzelura [ruxolitinib]) OR a topical PDE4 inhibitor (eg, Eucrisa [crisaborole]):
   ☐Tried and failed or has a contraindication or an intolerance to a 4-week trial of a topical corticosteroid approved or medically accepted for the beneficiary's diagnosis
   ☐Tried and failed or has a contraindication or an intolerance to an 8-week trial of a topical calcineurin inhibitor (eg, pimecrolimus, tacrolimus) approved or medically accepted for the beneficiary's diagnosis

3. For all other non-preferred TOPICAL Immunomodulators, Atopic Dermatitis:
   ☐Tried and failed or has a contraindication or an intolerance to the preferred topical Immunomodulators, Atopic Dermatitis approved or medically accepted for the beneficiary's diagnosis *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

4. For a targeted systemic Immunomodulator, Atopic Dermatitis (eg, Adbry, Cibinqo, Rinvoq):
   ☐Is prescribed the medication by or in consultation with an appropriate specialist (eg, dermatologist)
   ☐For the treatment of atopic dermatitis: Tried and failed or has a contraindication or an intolerance to both of the following (*check all that apply):*

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☐ One of the following:
- ☐ For the face, skin folds, or other critical areas, a 4-week trial of a low-potency (or higher) topical corticosteroid
- ☐ For other body areas, a 4-week trial of a medium potency or higher topical corticosteroid

☐ An 8-week trial of a topical calcineurin inhibitor (eg, pimecrolimus, tacrolimus)

☐ For the treatment of all other diagnoses – specify diagnosis: _____

☐ List other treatments tried (including start/stop dates, dose, outcomes, etc.): _____

_____

☐ For an oral JAK inhibitor (eg, Cibinqo, Rinvoq):
- ☐ Tried and failed at least one biologic as recommended in the JAK inhibitor's package labeling
- ☐ Has a contraindication or an intolerance to biologics as recommended in the JAK inhibitor's package labeling
- ☐ Is currently taking an oral JAK inhibitor

☐ For a NON-PREFERRED targeted systemic Immunomodulator, Atopic Dermatitis:
- ☐ Tried and failed or has a contraindication or intolerance to the preferred targeted systemic Immunomodulators, Atopic Dermatitis approved or medically accepted for the beneficiary's condition *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*
- ☐ Is currently using the requested non-preferred targeted systemic Immunomodulator, Atopic Dermatitis
  - What is the date of the beneficiary's last dose? _____

RENEWAL requests

1. For a non-preferred topical calcineurin inhibitor*:*
   - ☐ Has documented evidence of improvement of disease severity
   - ☐ Tried and failed or has a contraindication or an intolerance to the preferred topical calcineurin inhibitors *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*
2. For a topical JAK inhibitor (eg, Opzelura [ruxolitinib]) OR a topical PDE4 inhibitor (eg, Eucrisa [crisaborole]):
   - ☐ Has documented evidence of improvement of disease severity
3. For all other non-preferred TOPICAL Immunomodulators, Atopic Dermatitis:
   - ☐ Has documented evidence of improvement of disease severity
   - ☐ Tried and failed or has a contraindication or an intolerance to the preferred topical Immunomodulators, Atopic Dermatitis approved or medically accepted for the beneficiary's diagnosis *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*
4. For a targeted systemic Immunomodulator, Atopic Dermatitis (eg, Adbry, Cibinqo, Rinvoq):
   - ☐ Has documented evidence of improvement of disease severity
   - ☐ Is prescribed the medication by or in consultation with an appropriate specialist (eg, dermatologist)

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date: