



PRIOR AUTHORIZATION REQUEST FORM
EUCRISA®

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: Eucrisa® (crisaborole)

Dosing/Frequency: _____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
1. Is the requested medication being purchased by the provider's office and to be billed under the medical benefit ('buy-and-bill')?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Is this request for an expedited review? By checking the "Yes" box to request an expedited review (24 hours), you are certifying that applying the standard review time frame (72 hours) may place the member's life, health, or ability to regain maximum function in serious jeopardy.	<input type="checkbox"/>	<input type="checkbox"/>	
3. Does the member have a diagnosis of mild to moderate atopic dermatitis?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
4. Does documentation show that the member has had an adequate trial and failure of at least one topical corticosteroid, unless contraindicated?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
5. Does documentation show that the member has had an adequate trial and failure of topical tacrolimus or topical pimecrolimus, unless contraindicated?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

REAUTHORIZATION

1. Is the request for reauthorization of therapy?	<input type="checkbox"/>	<input type="checkbox"/>	
2. Has the member's therapy been re-evaluated within the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>	
3. Has the therapy shown to be effective with an improvement in condition?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation

4. Does the member show a continued need for the therapy?	<input type="checkbox"/>	<input type="checkbox"/>	Please provide documentation
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

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Policy: PHARM-009
 Origination Date: 09/28/2018
 Reviewed/Revised Date: 11/08/2023
 Next Review Date: 11/08/2024
 Current Effective Date: 12/01/2023

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