Iowa Department of Human Services

**Request for Prior Authorization**

# Crisaborole (Eucrisa)

**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 is required for Eucrisa (crisaborole). Payment will be considered for patients when the following criteria are met: 1) Patient has a diagnosis of mild to moderate atopic dermatitis; and 2) Patient is within the FDA labeled age; and 3) Patient has failed to respond to good skin care and regular use of emollients; and 4) Patient has documentation of an adequate trial and therapy failure with two preferred medium to high potency topical corticosteroids for a minimum of 2 consecutive weeks; and 5) Patient has documentation of a previous trial and therapy failure with a topical immunomodulator for a minimum of 4 weeks; and 6) Patient will continue with skin care regimen and regular use of emollients. 7) Quantities will be limited to 60 grams for use on the face, neck, and groin and 100 grams for all other areas, per 30 days. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

**Non-Preferred**

☐ Eucrisa

| Strength | Usage Instructions | Quantity | Day's Supply |
|---|---|---|---|
| | | | |

Diagnosis: _____

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

Document emollient use: Product name, dosing instructions & duration of use: _____

Will patient continue with skin care regimen and regular use of emollients?

☐ Yes Emollient to be used: _____ ☐ No

**Preferred Medium to High Potency Corticosteroid Trial 1:**

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

**Preferred Medium to High Potency Corticosteroid Trial 2:**

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

**Preferred Topical Immunomodulator Trial:**

Drug name & dose: _____ Trial dates: _____

Failure reason: _____

Affected area to be treated: _____

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 |
|---|---|
| | |

***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.*