Calcineurin Inhibitors – Washington Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No

2. If request is non-preferred, has patient had treatment with one or more preferred topical immunosuppressive medications on the Apple Health Preferred Drug List (AHPDL) that was ineffective, contraindicated or not tolerated?
   ☐ Yes. List each medication and duration of trial:

   Medication Name: _____ Duration: _____
   Medication Name: _____ Duration: _____
   Medication Name: _____ Duration: _____

   ☐ No. Explain why a preferred product(s) have not been tried: _____

3. Indicate patient's body surface area (BSA) involvement:

   Baseline: _____ Date: _____
   Current: _____ Date: _____

4. Indicate patient's diagnosis:
   ☐ Atopic dermatitis (questions 5 – 8)
   ☐ Vitiligo (questions 9 – 13)
   ☐ Other, specify: _____

For diagnosis of Atopic Dermatitis:

5. Has documentation been submitted of patient's baseline disease severity scale scoring (e.g., Investigator's Global Assessment (IGA) score; Eczema Area and Severity Index (EASI), Patient Oriented Eczema Measure (POEM), etc.)?
   ☐ Yes ☐ No

6. Has patient had treatment with at least one different topical corticosteroids that has been ineffective, contraindicated or not tolerated (minimum trial of 28 days each)? ☐ Yes ☐ No

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7. Indicate the following for patient. Check all that apply:
   ☐ Treatment is for sensitive areas (face, anogenital, skin folds)
   ☐ Documented history of steroid-induced atrophy

8. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response [e.g., reduction in body surface area involvement, achieved or maintained clear or minimal disease from baseline (equivalent to IGA sore of 0 or 1, experienced or maintained a decrease in EASI score)] from baseline? ☐ Yes ☐ No

For diagnosis of Vitiligo

9. Has patient had vitiligo for at least 3 months? ☐ Yes ☐ No

10. Has documentation been submitted of patient's baseline assessments of their disease and disease severity?
    ☐ Yes ☐ No

11. Has patient had treatment with at least one different medium-to-high potency topical corticosteroids (e.g. betamethasone, mometasone, clobetasol, fluocinonide) that has been ineffective, contraindicated or not tolerated (minimum trial of 2 months)? ☐ Yes ☐ No

12. Indicate the following for patient. Check all that apply:
    ☐ Treatment is for sensitive areas (face, anogenital, skin folds)
    ☐ Documented history of steroid-induced atrophy

13. **For continuation of therapy:** Has documentation been submitted demonstrating disease stability or a positive clinical response [e.g., improvement in F-VASI and/or T-VASI score, or reduction in total BSA involvement] from baseline? ☐ Yes ☐ No

CHART NOTES AND BASELINE ASSESMENTS ARE REQUIRED WITH THIS REQUEST

Prescriber signature	Prescriber specialty	Date