



Please complete ALL information below and fax your request to 1-888-671-5285

### Eucrisa® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)	
<b>Select the diagnosis below:</b>	
<input type="checkbox"/> Atopic dermatitis	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
<b>Clinical information:</b>	
Does the patient have a trial and failure, contraindication, or intolerance to one prescription strength topical corticosteroid? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If No, is the affected area sensitive (i.e., face, axillae, groin)? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.