



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

### Topical Steroids Prior Authorization Request Form

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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 <b>generic substitution</b> is acceptable		Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			

Clinical Information (required)
<b>What is the patient's diagnosis for the medication being requested (specify all)?</b> _____
ICD-10 Code(s): _____
<b>Medication history:</b> Has the patient had an inadequate response to or inability to tolerate THREE prescription strength, generic topical steroids? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>yes</b> , please specify: _____

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

\_\_\_\_\_

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

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