

Member Name: _____ Member ID: _____ Member DOB: _____
Drug Name: _____ Strength: _____ Directions: _____
Physician Name: _____ Physician Phone #: _____ Specialty: _____
Physician Fax #: _____ Pharmacy Name: _____ Pharmacy Phone: _____

Horizon NJ Health
Pimecrolimus (Elidel), Tacrolimus (Protopic) Ruxolitinib (Opzelura), and Crisaborole (Eucrisa) – Medical Necessity Request

Complete this page for Initial Requests

1. What is/are the affected area(s)? _____
2. For Pimecrolimus, Tacrolimus, and Ruxolitinib requests: Is the member immunocompromised? **Yes or No**
 - If Yes, please provide the diagnosis or treatment that causes the member to be immunocompromised.

3. Has the member tried and failed a topical corticosteroid (e.g., OTC hydrocortisone, hydrocortisone valerate, betamethasone, fluocinolone, mometasone, fluticasone, desoximetasone)? **Yes or No**
 - If No, can the patient try a topical corticosteroid instead? **Yes or No**
 - If Yes, please call the prescription in to the pharmacy.
 - If No, please provide the clinical reason(s) why the member cannot try a topical corticosteroid first.

4. For Pimecrolimus, Ruxolitinib, and Eucrisa requests: Can patient try Tacrolimus Ointment? **Yes or No**
 - If Yes, please notify the pharmacy of the change and proceed to next section.
 - If No, please provide the clinical reason(s) why the member cannot try Tacrolimus Ointment.

5. For Ruxolitinib requests:
 - Is affected body surface area 20% or less? **Yes or No**
 - Will member be taking any therapeutic biologics, other Janus Kinase (JAK) inhibitors, or potent immunosuppressants (such as azathioprine or cyclosporine)? **Yes or No** Will member continue to use emollients concomitantly in problem areas (e.g., face, neck, genitals) to help flares? **Yes or No**

Diagnosis Information (please indicate diagnosis):

- Atopic Dermatitis/Eczema
- Dermatitis
 - What type of dermatitis does the member have?
 - Atopic
 - Other: _____
- Psoriasis
 - What type of psoriasis does the member have?
 - Facial
 - Inverse/Intertriginous
 - Other: _____
- Graft-Versus-Host Disease (GVHD)
- Other: _____

Horizon NJ Health

Physician office's signature* _____ Print Name _____

*Form must be completed and signed by physician or licensed representative from the physician's office

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Pimecrolimus (Elidel), Tacrolimus (Protopic), Ruxolitinib (Opzelura), and Crisaborole (Eucrisa) – Medical Necessity Request

Complete this page for Subsequent Requests

Diagnosis Information (please indicate diagnosis):

Atopic Dermatitis/Eczema

Dermatitis

- What type of dermatitis does the member have?

Atopic

Other: _____

Psoriasis

- What type of psoriasis does the member have?

Facial

Inverse/Intertriginous

Other: _____

Graft-Versus-Host Disease (GVHD)

Other: _____

Physician office's signature* _____ Print Name _____

*Form must be completed and signed by physician or licensed representative from the physician's office