



Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Topical Immunomodulators (Atopic Dermatitis) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months ; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Topical Immunomodulators (Atopic Dermatitis)**. Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: [1-866-331-2104](tel:1-866-331-2104)]. If you have any questions or concerns, please call [1-866-331-2103](tel:1-866-331-2103). **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: [Pharmacy | Community Provider Portal | Kaiser Permanente](#)**

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Provider Name: _____ Specialty: _____ Provider NPI: _____
Provider Address: _____
Provider Phone #: _____ Provider Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____
Pharmacy Phone #: _____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____
Drug 2: Name/Strength/Formulation: _____
Sig: _____

5 – Diagnosis

Diagnosis of Atopic Dermatitis?
 No Yes
Severity: Mild Moderate Severe
If “No” to above, provide details: _____

6 – Clinical Criteria

Criteria for Elidel, Protopic, and tacrolimus:

1. Select indication and age for use:

- Elidel Mild to Moderate for ages ≥ 2 years old
 - Protopic 0.03%: Moderate to Severe for ages ≥ 2 years old
 - Protopic 0.1%: Moderate to Severe for ages ≥ 16 years old
- AND

2. Documented of 8 weeks trial and failure (or contraindication) of one Topical corticosteroid of medium to high potency (i.e., mometasone, fluocinolone)?

- No Yes

Criteria for Eucrisa and Opzelura:

1. Select indication and age for use:

- Eucrisa: Mild to Moderate for ages ≥ 3 months old
- Opzelura: Mild to Moderate for ages ≥ 12 years old

Note: Opzelura is not covered for the indication of nonsegmental vitiligo in adult and pediatric patients ≥ 12 years old.

1. Document trial and failure or contraindication:

- Eucrisa- Prior trial for 30 days and failure or contraindication to:
 - One topical corticosteroid of medium to high potency (i.e., mometasone, fluocinolone) AND
 - One topical calcineurin inhibitors (tacrolimus or pimecrolimus)

- No Yes

- Opzelura-Prior trial for 8 weeks and failure or contraindication to:
 - One topical corticosteroid of medium to high potency (i.e., mometasone, fluocinolone) AND
 - One topical calcineurin inhibitors (tacrolimus or pimecrolimus), AND
 - Dupixent

- No Yes

Criteria for Adbry:

1. Patient is using for moderate to severe atopic dermatitis for ages ≥ 18 years old, AND

- No Yes

2. Prior documented trial and failure of 30-day trial of the following:

- a. One topical corticosteroid of medium to high potency (i.e. mometasone, fluocinolone), OR
- b. One topical calcineurin inhibitor (tacrolimus or pimecrolimus)

- No Yes

Criteria for Zoryve cream 0.15%:

1. Patient is using for mild to moderate atopic dermatitis for ages ≥ 6 years old

- No Yes

7 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
 2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**
-

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:

Date:

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