Atopic Dermatitis Agents: Crisaborole (Eucrisa™)

Please fax this completed form to (833) 645-2734 OR mail to: Pharmacy Services| 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at CoverMyMeds.com.

Coordinated Care of Washington, Inc. Preferred Drug list: *https://pharmacy.envolvehealth.com/content/dam/centene/envolve-pharmacy-solutions/pdfs/PDL/FORMULARY-CoordinatedCare_Washington.pdf*

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care 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
   If yes, is there documentation of disease stability or improvement from baseline? ☐ Yes ☐ No

2. Indicate patient's diagnosis:
   - ☐ Atopic dermatitis
   - ☐ Other. Specify:

3. Does the patient have a history of trial and failure of at least TWO preferred topical corticosteroids (medium or higher potency) for daily treatment for at least minimum 28-days within the previous 6 months (check all that apply)?
   - ☐ Yes. Specify which products:
   - ☐ No
   - ☐ Topical steroids contraindicated.
     - ☐ Treatment of sensitive areas (face, anogenital, skin folds) not responding to low potency desonide or hydrocortisone
     - ☐ History of steroid induced atrophy
     - ☐ Long-term uninterrupted use
     - ☐ Other. Explain:
   - ☐ None of the above

4. Has the patient tried and failed at least ONE topical calcineurin inhibitors (i.e., pimecrolimus, tacrolimus) for at least 28-days (check all that apply)?
   - ☐ Yes
   - ☐ No
   - ☐ Topical calcineurin inhibitors (i.e., pimecrolimus, tacrolimus) are contraindicated.
     - ☐ Patient is less than 2 years old.
     - ☐ Other. Explain:
   - ☐ None of the above

Baseline evaluation of the disease state (atopic dermatitis), including severity of symptoms and chart notes are required with this request

Prescriber signature	Prescriber specialty	Date

Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)