Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Eucrisa (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of Eucrisa (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Eucrisa (crisaborole)

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Has Aetna Better Health authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, then skip to question 3.]

2. Does the patient have an improvement in lesions (i.e., compliance and adherence to treatment; Investor's Static Global Assessment (ISGA) of 0 or 1 clear or almost clear or at least 20 percent symptom improvement, e.g., reduction in lesions)? Y N

   [No further questions.]

3. Does the patient have the diagnosis of mild to moderate atopic Y N

dermatitis?

[If no, then no further questions.]

4. Is the requested drug being prescribed by or in consultation with a dermatologist, allergist or immunologist? Y N

   [If no, then no further questions.]

5. Has the patient had an inadequate response or intolerable side effects to ALL of the following: A) Two preferred (medium potency) topical corticosteroids (e.g. hydrocortisone, triamcinolone, mometasone, betamethasone, fluticasone), B) One topical calcineurin inhibitors (e.g., tacrolimus)? Y N

   [If no, then no further questions.]

6. Is the patient 2 years of age or older? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date