TEXAS MEDICAID
Clinical Edit Prior Authorization
crisaborole (EUCRISA)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: CLINICAL PRIOR AUTHORIZATION CRITERIA

☐ Indicate Primary Diagnosis: _____ ICD 10 Code: _____

1. Does the client have a diagnosis of atopic dermatitis in the last 730 days?

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Is the client less than (<) 2 years of age?

   ☐ Yes (Approve - 180 days) ☐ No (Go to #3)

3. Does the client have a claim for a topical steroid in the last 730 days?

   Examples include aclometasone dipropionate, amcinonide, betamethasone (DIPROLENE), betamethasone valerate (LUXIQ), clobetasol (CLOBEX, OLUX), clobetasol propionate (TEMOVATE), clocortolone pivalate (CLODERM), CORDRAN, DERMA-SMOOTHE-FS, desoximetasone (TOPICORT), desonide (DESONATE), diflorasone diacetate (APEXICON), fluocinolone, fluticasone (CUTIVATE), fluocinonide (FLUOCINONIDE-E, VANOS), flurandrenolide, halobetasol propionate (BRYHALI, LEXETTE, ULTRAVATE), halcinonide (HALOG), hydrocortisone, hydrocortisone butyrate, hydrocortisone valerate, mometasone furoate, PANDEL, PREDNICARBATE, triamcinolone, TEXACORT, and TRIANEX.

   ☐ Yes (Approve - 180 days) ☐ No (Deny)

STEP 3: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.

For questions, please call Navitus Customer Care at 1-877-908-6023.