TEXAS MEDICAID
Clinical Edit Prior Authorization
tacrolimus (PROTOPIC) 0.1%

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: MEDICATION INFORMATION	
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Please indicate ONE (1) of the following:

☐ STAR / STAR KIDS client **(Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ CHIP / PERINATE client **(Go to Step 4)**

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 30-day treatment trial with at least one (1) preferred agent in the last 180 days?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #2)

2. Is there documented allergy or contraindication to preferred agents in this class?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Deny)

STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Does the client have a diagnosis of localized skin graft versus host disease in the last 365 days?

   ☐ Yes (Go to #2) ☐ No (Go to #3)

2. Has the client had a bone marrow transplant in the last 365 days?

   ☐ Yes (Approve - 365 days) ☐ No (Go to #3)

3. Is the client less than (<) 16 years of age?

   ☐ Yes (Deny) ☐ No (Go to #4)

4. Does the client have a diagnosis of Atopic Dermatitis (eczema) in the last 730 days?

   ☐ Yes (Go to #5) ☐ No (Deny)

5. Does the client have a history of a topical steroid or nystatin / triamcinolone prescription in the last 730 days?

   ☐ Yes (Go to #7) ☐ No (Go to #6)

6. Does the client have a history of a prior pimecrolimus (ELIDEL) / tacrolimus (PROTOPIC) prescription in the last 365 days?

   ☐ Yes (Go to #7) ☐ No (Deny)

7. Has the client had a diagnosis of HIV or Immune System Disorder in the last 730 days?

   ☐ Yes (Deny) ☐ No (Go to #8)

8. Does the client have a history of HIV drugs or immunosuppressants in the last 730 days?

   ☐ Yes (Deny) ☐ No (Go to #9)

9. Does the client have a history of antineoplastic agents in the last 730 days?

   ☐ Yes (Deny) ☐ No (Go to #10)

10. Does the client have a history of a skin absorption disorder or a skin malignancy in the last 730 days?

    ☐ Yes (Deny) ☐ No (Go to #11)

11. Does the client have a history of a prior pimecrolimus (ELIDEL) / tacrolimus (PROTOPIC) prescription for less than or equal to (≤) 180 days in the last 200 days?

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

STEP 5: 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.