Fax completed form to Navitus at: 855-668-8553
For questions, please call: 877-908-6023

TEXAS MEDICAID

Drug Prior Authorization
Topical Immunomodulators: tacrolimus (PROTOPIC) 0.1%

Request Information (required)
This request is: ☐ **Expedited* (Urgent)** ☐ **Standard (Non-Urgent)** *Expedited means the standard review time may seriously harm the member's life, health, or ability to regain maximum function.

Member Information (required)			Prescriber Information (required)		
Member Name:			Prescriber Name:		
Member Insurance ID #:			NPI # :	Specialty:	
Date of Birth:			Office Phone:		
Member Phone:			Office Fax:		
Member Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:

Please fill out the following information:

1. Medication Requested (Name):
(Go to #2)

2. Quantity Requested:
(Go to #3)

3. Dose Requested (Strength):
(Go to #4)

4. Dosing Instructions:
(Go to #5)

Required Criteria

5. Provide primary diagnosis including ICD-10 code(s):
(Go to #6)

6. Please indicate the requested drug's formulary status: *(Formulary available at www.txvendordrug.com)

- ◯ Non-Preferred Drug (NPD or NAP)
  (Go to #7)
- ◯ Preferred Drug (PDL)
  (Go to #10)
- ◯ No Status, Drug is not in a Market Basket
  (Go to #10)
- ◯ N/A as this request is for a CHIP/PERINATE member
  (Go to #10)

Preferred Drug List (PDL) Criteria (required for non-preferred products)

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

- ◯ Yes
  (Go to #10)
- ◯ No
  (Go to #8)

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

- ◯ Yes
  (Go to #10)
- ◯ No
  (Go to #9)

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

- ◯ Yes
  (Go to #10)
- ◯ No (Deny)
  (Go to #10)

Clinical Criteria (required)

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

- ◯ Yes
  (Go to #11)
- ◯ No
  (Go to #12)

11. Has the member had a bone marrow transplant in the last 365 days?

- ◯ Yes (Approve - 365 days)
  (Go to #21)
- ◯ No
  (Go to #12)

12. Is the member less than (<) 16 years of age?

- ◯ Yes (Deny)
  (Go to #13)
- ◯ No
  (Go to #13)

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

- ◯ Yes
  (Go to #14)
- ◯ No (Deny)
  (Go to #14)

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

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

- ◯ Yes
  (Go to #16)
- ◯ No
  (Go to #15)
- ◯ No, and the medication will be applied to a thin skinned area.
  (Go to #16)

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

- ◯ Yes
  (Go to #16)
- ◯ No (Deny)
  (Go to #16)

16. Has the member had a diagnosis of human immunodeficiency virus (HIV) or Immune System Disorder in the last 730 days?

- ◯ Yes (Deny)
  (Go to #17)
- ◯ No
  (Go to #17)

17. Does the member have a history of human immunodeficiency virus (HIV) drugs or immunosuppressants in the last 730 days?

Examples include: abacavir (ZIAGEN), abacavir-lamivudine- zidovudine (TRIZIVIR), AFINITOR, AFINITOR DISPERZ, APTIVUS, ATRIPLA, azathioprine (IMURAN), COMPLERA, CRIXIVAN, cyclosporine (GENGRAF, NEORAL, SANDIMMUNE), didanosine (VIDEX), EDURANT, EMTRIVA, EPZICOM, EVOTAZ, FUZEON, GENVOYA, INTELENCE, INVIRASE, ISENTRESS, KALETRA, lamivudine (EPIVIR), lamivudine -zidovudine (COMBIVIR), LEXIVA, mycophenolate (CELLCEPT, MYFORTIC), nevirapine (VIRAMUNE), NORVIR, PREZCOBIX, PREZISTA, RESCRIPTOR, REYATAZ, SELZENTRY, sirolimus (RAPAMUNE), stavudine (ZERIT), STRIBIL, SUSTIVA, tacrolimus (ASTAGRAF XL, ENVARSUS XR, PROGRAF), TIVICAY, TRIUMEQ, TRUVADA, VIRACEPT, VIREAD, VITEKTA, zidovudine (RETROVIR), and ZORTRESS.

- ◯ Yes (Deny)
  (Go to #18)
- ◯ No
  (Go to #18)

18. Does the member have a history of antineoplastic agents in the last 730 days?

Examples of antineoplastic agents include: ALKERAN, anastrozole (ARIMIDEX), azacitidine, bicalutamide (CASODEX), BICNU, BOSULIF, capecitabine (XELODA), CAPRELSA, COMETRIQ, COSMEGEN, cyclophosphamide, CYTARABINE, dutasteride (AVODART), EMCYT, ERIVEDGE, etoposide, exemestane (AROMASIN), FARESTON, FARYDAK, finasteride (PROSCAR), fluorouracil, flutamide, GLEEVEC, GLEOSTINE, HEXALEN, HYCAMTIN, hydroxyurea (DROXIA), IBRANCE, ICLUSIG, IMBRUVICA, INLYTA, IRESSA, LENVIMA, letrozole (FEMARA), LEUKERAN, LYSODREN, MATULANE, megestrol acetate (MEGACE), MEKINIST, mercaptopurine (PURIXAN), methotrexate (RHEUMATREX, TREXALL), mitomycin, mitoxantrone, MYLERAN, NEXAVAR, NILANDRON, ONCASPAR, raloxifene (EVISTA), SPRYCEL, SUTENT, SYNRIBO, TABLOID, tamoxifen (SOLTAMOX), TARCEVA, TARGRETIN, TASIGNA, temozolomide (TEMODAR), teniposide, TYKERB, vinblastine, VOTRIENT, XALKORI, XTANDI, ZELBORAF, ZOLINZA, ZYDELIG, ZYKADIA, and ZYTIGA.

- ◯ Yes (Deny)
  (Go to #19)
- ◯ No
  (Go to #19)

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

- ◯ Yes (Deny)
  (Go to #20)
- ◯ No
  (Go to #20)

20. Does the member a have 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)
  (Go to #21)
- ◯ No (Deny)
  (Go to #21)

Additional Information

21. Please provide any additional information we should consider (or attach any supporting documents):
(END)

Submission Information (required)

Prescriber Signature: _____ **Date:** _____

**** PLEASE FAX COMPLETED FORM TO: 855-668-8553 ****

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