RxAdvance

CRISABOROLE (EUCRISA) PRIOR AUTHORIZATION REQUEST

Please send the completed Prior Authorization form and any additional information to RxAdvance by fax to:
508-452-0076 for standard requests
508-452-6421 for expedited requests

Note: Please provide as much information as possible on this form. Missing data may cause processing delays for requested prior authorization(s). Attach additional sheets to this form if necessary. An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered health plan benefit and medically necessary with prior authorization as per plan policy and procedures.

Patient Information	
Patient Name	
Patient Health Plan	
Patient Member ID #	
Patient Date of Birth	
Patient Phone #	

Prescriber Information	
Prescriber Name	
Prescriber Address	
Prescriber Phone #	
Prescriber Fax #	
Prescriber Specialty	
Prescriber DEA #	
Prescriber NPI #	

Drug & Medical Information	
Requested Drug(s) & Strength(s)	
Quantity(ies)	
Days Supply	
Expected Duration of Therapy	
Directions	
Diagnosis & Diagnosis Code(s) (ICD-10 Standard Codes)	
Drugs Used Previously to Treat the Same Condition	
Additional Clinical Information or History Please include any relevant test results and/or medical record notes	

RxAdvance's maximum allowable dosage is 60 grams (1 tube) per 30 days.
Does the dose exceed 60 grams (1 tube) per 30 days?

☐ Yes ☐ No

Please answer the following questions if the request is for **initial authorization**:

1. Patient has a diagnosis of atopic dermatitis ☐ Yes ☐ No
2. Patient has a documented failure to a 2-week trial of one generic medium-to-very high potency topical corticosteroid

   ☐ Yes. Please specify drug name, dose, and start and end dates of therapy:

   _____

☐ No, patient has a contraindication to medium-to-very high potency corticosteroid (e.g., areas involving the face, neck or intertriginous areas)
☐ No, patient has experienced significant adverse effects. Please specify the adverse effects:

_____

☐ None of the above

Please answer the following questions if the request is for **continued therapy**:

1. Patient is currently receiving the drug that has been authorized by RxAdvance

   ☐ Yes – Continue to the next question
   ☐ No – Please answer questions in the initial authorization section

2. Patient is responding positively to therapy ☐ Yes ☐ No

Attestation: *I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, Insurer, Medical Group, or its designated representatives may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.*	
Signature of Prescriber or Authorized Representative	Date (MM/DD/YYYY)
Print Prescriber or Authorized Representative Name	