Mountain-Pacific Quality Health
Partnering within our communities to provide solutions for better health
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Montana Healthcare Progams Prior Authorization Request Form for Use of Eucrisa (crisaborole)

Member Name:	DOB:	Date:
Member ID:	Prescriber Phone:	
Prescriber Name/Specialty if applicable:	Prescriber Fax:	

Please complete below information for applicable situation, Initiation or Continuation of therapy:

☐ INITIATION OF THERAPY

1. Member must be ≥3 months of age: ☐ Yes ☐ No
2. Member has a diagnosis of:
   - ☐ **Atopic Dermatitis**
   - ☐ **Eczema**
3. Member has had a documented baseline assessment to allow for documentation of positive clinical response: ☐ Yes ☐ No
4. **Members 3 months to 17 years of age**: Member has had an inadequate treatment response, intolerance or contraindication to a **preferred low-mid** potency topical corticosteroid.
   - ☐ Drug Name: _____
5. **Members 18 years of age or older**: Member has had an inadequate treatment response, intolerance or contraindication to a **preferred high** potency topical corticosteroid.
   - ☐ Drug Name: _____
6. If ≥2 years of age, member must also have had an inadequate treatment response, intolerance or contraindication to one of the following (*subject to preferred drug list requirements*):
   - ☐ Elidel (pimecrolimus) Date: _____
   - ☐ Protopic (tacrolimus) Date: _____

NOTE: Inadequate treatment response to topical therapy is defined as failure to achieve and maintain remission or a low disease activity state despite treatment with a daily regimen, applied for ≥ 28 days or for the maximum duration recommended by the product prescribing information (e.g., 14 days for high or very-high potency topical corticosteroids).

LIMITATIONS:
A maximum of 1 tube per month will be authorized.

Initial authorization will be issued for 6 months.

☐ CONTINUATION OF THERAPY

1) Does the member have documentation of positive clinical response to Eucrisa therapy (e.g., reduction in body surface area involvement, reduction in pruritus severity or decrease in severity index using a scoring tool)? ☐ Yes ☐ No

Reauthorization will be issued for 12 months.

Please complete form, including required attachments and fax to:
Drug Prior Authorization Unit at 1-800-294-1350