Montana Healthcare Programs Prior Authorization Request Form for Use of Eucrisa (crisaborole)

<table>
<thead>
<tr>
<th>Member Name:</th>
<th>DOB:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member ID:</td>
<td>Prescriber Phone:</td>
<td></td>
</tr>
<tr>
<td>Prescriber Name/Specialty if applicable:</td>
<td>Prescriber Fax:</td>
<td></td>
</tr>
</tbody>
</table>

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

4/2020