



Nevada Medicaid

Submit fax request to: 855-455-3303

Please note: All information below is required to process this request.

Protopic® (tacrolimus) Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:	Dosage Form:	
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below:					
<input type="checkbox"/> Moderate to severe atopic dermatitis					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical information:					
Will the requested medication be used chronically? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is the member immunocompromised? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For tacrolimus (generic for Protopic) requests, also answer the following:					
Has the member experienced a side effect, allergy, or treatment failure with the brand formulation of the requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Has the member experienced therapeutic failure of TWO preferred medications within the same drug class? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes , list ALL medications: _____					
Does the member have an allergy, contraindication, drug-to-drug interaction, or a history of unacceptable/toxic side effects with ALL preferred medications within the same drug class? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes , list ALL medications & allergy/contraindication/interaction/side effects: _____					
Is the non-preferred medication being requested because it is being used for a unique indication that is supported by peer-reviewed literature or an FDA-approved indication? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes , list the unique indications: _____					

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-855-455-3303.

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