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:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Moderate to severe atopic dermatitis

❑ Other diagnosis:_____ ICD-10 Code(s): _____

Clinical information:

Will the requested medication be used chronically? ❑ **Yes** ❑ **No**

Is the member immunocompromised? ❑ **Yes** ❑ **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? ❑ **Yes** ❑ **No**

Has the member experienced therapeutic failure of TWO preferred medications within the same drug class? ❑ **Yes** ❑ **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? ❑ **Yes** ❑ **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? ❑ **Yes** ❑ **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.

Office use only: Protopic_NevadaMedicaid_2019Jul-W