Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Topical Immunomodulators (Atopic Dermatitis) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 12 months ; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Topical Immunomodulators (Atopic Dermatitis).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at:** Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Provider Name: _____ Specialty: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5 – Diagnosis

Diagnosis of Atopic Dermatitis?
□ No □ Yes
Severity: □ Mild □ Moderate □ Severe

If "No" to above, provide details: _____

6 – Clinical Criteria

Criteria for Elidel, pimecrolimus, Protopic, and tacrolimus:

1. Select indication and age for use:
   - □ Elidel Mild to Moderate for ages ≥ 2 years old
   - □ Protopic 0.03%: Moderate to Severe for ages ≥ 2 years old
   - □ Protopic 0.1%: Moderate to Severe for ages ≥ 16 years old

   AND
2. Documented of 8 weeks trial and failure (or contraindication) of one topical corticosteroid of medium to high potency (i.e., mometasone, fluocinolone)?
   - □ No □ Yes

Criteria for Eucrisa and Adbry

1. Select indication and age for use:
   - □ Eucrisa: Mild to Moderate for ages ≥ 3 months old
   - □ Adbry: Moderate to Severe for ages ≥ 12 years old
2. Documented of 30 days trial and failure (or contraindication) of one topical corticosteroid of medium to high potency (i.e., mometasone, fluocinolone)? OR
   - □ No □ Yes
3. Documented of 30 days trial and failure (or contraindication) of one (1) topical calcineurin inhibitors (tacrolimus or pimecrolimus)
   - □ No □ Yes

Criteria for *Opzelura, Ebglyss, **Nemluvio

1. Select indication and age for use:
   - □ Opzelura: Mild to Moderate for ages ≥ 12 years old
   - □ Ebglyss: Moderate to Severe for ages ≥ 12 years old
   - □ Nemluvio: Moderate to Severe for ages ≥ 12 years old
2. Documented of 8 weeks trial and failure (or contraindication) of one topical corticosteroid of medium to high potency (i.e., mometasone, fluocinolone)? AND
   - □ No □ Yes
3. Documented of 8 weeks trial and failure (or contraindication) of one topical calcineurin inhibitors (tacrolimus or pimecrolimus)? AND
   - □ No □ Yes
4. Documented of 8 weeks trial and failure (or contraindication) of Dupixent
   - □ No □ Yes

Note:

***Opzelura is not covered for the indication of nonsegmental vitiligo in adult and pediatric patients ≥ 12 years old.**

****Additional Criteria for Nemluvio for Prurigo Nodularis**

1. Patient is ≥ 18 years old
   - □ No □ Yes
2. Diagnosis of Prurigo Nodularis
   - □ No □ Yes
3. Documented of 8 weeks trial and failure (or contraindication) of Dupixent
   - □ No □ Yes

Criteria for Zoryve cream 0.15%:

1. Patient is ≥ 6 years old
   - □ No □ Yes
2. Diagnosis of mild to moderate atopic dermatitis?
   - □ No □ Yes

Criteria for Zoryve foam 0.3 %:

1. Patient is ≥ 9 years old?
   □ No □ Yes
2. Diagnosis of seborrheic dermatitis?
   □ No □ Yes

7 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**

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