Topical Immunomodulators Prior Worksheet
New York State Medicaid Clinical Drug Review Program

# Instructions

## Program Information

* Drugs included in the Clinical Drug Review Program require prior authorization.
* A list of CDRP drugs is available at [www.nyhealth.gov](http://www.nyhealth.gov) and at [http://newyork.fhsc.com](http://newyork.fhsc.com/).
* Fax requests are NOT permitted for some CDRP drugs.

## Prescriber Procedure

* Each CDRP drug has specific clinical information that must be provided before a prior authorization will be issued. The clinical criteria relevant to each specific CDRP drug are listed at the end of the prior authorization worksheet.
* If your fax includes the standardized fax form, only the Member Name, ID, DOB, and Clinical Criteria need to be completed and faxed as an attachment to process your request.
* PA requests from 3rd party agencies to include faxes or any media are not allowed.  Please have the prescribing physician or an agent employed by the prescribing practitioner contact our department for consideration of this request.

Topical Immunomodulators Prior Authorization Worksheet
New York State Medicaid Clinical Drug Review Program

***If your fax includes the standardized fax form, only the Member Name, ID, DOB, and Clinical Criteria need to be completed and faxed as an attachment to process your request.***

| Enrollee Information |
| --- |
| Enrollee Name:      | Date of Birth:      |
| enrollee medicaid id number (2 letters, 5 numbers, 1 letter):      |

| Prescriber Information |
| --- |
| prescriber Name:      | contact person:      |
| prescriber 10-digit national provider identifier (NPI):      | office Phone Number:      | office Fax number:      |

| Clinical Criteria |
| --- |
| Which drug are you requesting? (Document name, strength, direction, quantity, and number of refills.) |
| Elidel 1% cream and Protopic 0.03% ointment have a minimum age limit of 2 years. Protopic 0.1% ointment has a minimum age limit of 16 years.  |
| Name: | [ ]  Elidel | [ ]  Protopic |
| strength: |       |
| direction: |       |
| quantity: |       |
| refills: |       |
| Days Supply: |       |
| Is the patient diagnosed with atopic dermatitis? |
| [ ]  Yes | [ ]  No | If no, what diagnosis are you using the product for?      |
| Did the patient attempt using a topical corticosteroid for four (4) weeks? |
| [ ]  Yes | [ ]  No | If no, please provide clinical reason:      |
| Has the patient experienced any of the following? Please check all that apply and document what the failure, adverse reaction, and/or contraindication was. |
| [ ]  | A treatment failure with a topical corticosteroid |
|  |       |
| [ ]  | A clinically significant adverse reaction with a topical corticosteroid |
|  |       |
| [ ]  | A contraindication to a topical corticosteroid |
|  |       |
| Is the patient immunocompromised? |
| [ ]  Yes | [ ]  No | If the answer is yes, does the patient have HIV with facial seborrheic dermatitis?      |

I attest that this is medically necessary for this patient and that all of the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by New York Medicaid.

|  |  |  |
| --- | --- | --- |
|  |  |       |
| prescriber Signature |  | date |