Prior Authorization Request Form for
Crisaborole (Eucrisa)

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth _____ Secure Fax #: _____

Step 2 **Please complete the clinical assessment:**

1. Does the patient have a diagnosis of mild to moderate atopic dermatitis?	☐ **Yes** **Proceed to question 2**	☐ **No** **STOP** **Coverage not approved**
2. Is the requested medication being prescribed by an Allergist, Immunologist or Dermatologist?	☐ **Yes** **Proceed to question 3**	☐ **No** **STOP** **Coverage not approved**
3. Does the patient have a contraindication to, intolerability to, or failed treatment with, a two week trial of at least one medium to high potency topical corticosteroid?	☐ **Yes** **Proceed to question 4**	☐ **No** **STOP** **Coverage not approved**
4. Does the patient have a contraindication to, intolerability to, or failed treatment with, a two week trial of a second agent including one of the following: 1) an additional medium - high potency topical corticosteroid OR 2) topical calcineurin inhibitor (such as tacrolimus, Elidel)?	☐ **Yes** **Sign and date below**	☐ **No** **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date.

_____ _____
Prescriber Signature Date

[14 February 2018]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: