Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Eucrisa (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Eucrisa (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Eucrisa (crisaborole)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Member information

Member name: _____

Member ID: _____

Member Group No.: _____

Member DOB: _____

Member phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

1. Has the plan authorized this medication in the past for this member (i.e., previous authorization is on file under this plan)? Y N

   [If no, then skip to question 3.]

2. Does the member have an improvement in lesions (i.e., compliance and adherence to treatment; Investor's Static Global Assessment (ISGA) of 0 or 1 clear or almost clear or responding to therapy such as reduction in lesions)? Y N

   [No further questions.]

3. Does the member have the diagnosis of mild to moderate atopic dermatitis? Y N

[If no, then no further questions.]

4. Is the requested drug being prescribed by or in consultation with a dermatologist, allergist or immunologist? Y N

   [If no, then no further questions.]

5. Has the member had an inadequate response or intolerable side effects to ALL of the following: A) Two preferred (medium potency) topical corticosteroids (such as hydrocortisone, triamcinolone, mometasone, betamethasone, fluticasone); or for sensitive areas, such as the face, one preferred low potency topical corticosteroid, B) Tacrolimus, C) Elidel when preferred agents have failed, D) At least one oral systemic therapy such as methotrexate (MTX), cyclosporine, azathioprine or mycophenolate? Y N

   [If no, then no further questions.]

6. Is the member 2 years of age or older? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature **Date**