

# ELIDEL – STEP THERAPY

## PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross<sup>®</sup> BlueShield<sup>®</sup> of South Carolina

Patient Information	
Name:	Insurance ID #:
Group #:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

**When this form is complete, please fax to Caremark at 888-836-0730.**

This fax machine is in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 800-294-5979 with any questions concerning prior authorization procedures.

- Does the patient have the diagnosis of mild to moderate atopic dermatitis (eczema)?  Y  N
- Has the patient been advised that Elidel should only be used to treat the immediate problem and then should be stopped when the condition improves?  Y  N
- Is the patient 2 years of age or older?  
[If the answer to this question is no, no further questions are required.]  Y  N
- Is the patient a candidate for medium to high potency corticosteroid therapy?  
[If the answer to this question is no, no further questions are required.]  Y  N
- Has the patient tried and had an inadequate response to at least two medium or higher potency topical corticosteroids?  
[If the answer to this question is yes, no further questions are required.]  Y  N
- Does the patient have a contraindication or allergy to all corticosteroids (not the vehicles)?  Y  N

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**Comments:** \_\_\_\_\_

*Information on this form is accurate as of the date below.*

<b>Prescriber's Signature:</b>	<b>Date:</b>
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