PROTOPIC – STEP THERAPY

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM
BlueCross BlueShield 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 1-888-836-0730.

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 1-800-294-5979 with any questions concerning prior authorization procedures.

1. Is the patient 2 years of age or older? Y N
2. Does the patient have the diagnosis of mild to moderate atopic dermatitis (eczema)? Y N
3. Has the patient tried and had an inadequate response to at least two medium or higher potency topical corticosteroids? Y N

[If the answer to this question is yes, then skip to question 6.]

4. Is the patient a candidate for medium to high potency corticosteroid therapy? Y N

[If the answer to this question is no, then skip to question 6.]

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5. Does the patient have a contraindication or allergy to all topical corticosteroids (not the vehicle)? Y N

6. Is the prescription for Protopic 0.1% Ointment?
[If the answer to this question is no, skip to question 8.] Y N

7. Is the patient 16 years of age or older? Y N

8. Has the patient been advised that Protopic should only be used to treat the immediate problem and then should be stopped when the condition improves? Y N

Comments: ______________________________

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

Prescriber's Signature:	**Date:**

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