



**Elidel® (pimecrolimus) Prior Authorization Request Form**

**Please fax the completed request form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 800-466-9854. For additional information call 314-214-8282 or 800-647-2240.**

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Pharmacy ID: \_\_\_\_\_  
(located on bottom right of insurance card)

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Requesting Physician: \_\_\_\_\_  
(Please print)

Specialty: \_\_\_\_\_

Office Contact Person: \_\_\_\_\_

Phone #: (\_\_\_\_)\_\_\_\_ - \_\_\_\_ ext \_\_\_\_

Medication/dose Requested: \_\_\_\_\_

Fax #: \_\_ (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_

Expected Duration of Therapy: \_\_\_\_\_

ICD-9 \_\_\_\_\_

1. Is the patient two years of age or older?	YES	NO
2. Does the patient have a diagnosis of mild to moderate atopic dermatitis (eczema)?	YES	NO
3. Has the patient tried and failed at least two topical medium-to-high potency corticosteroids?	YES	NO
4. Does the patient have a contraindication or allergy to all corticosteroids (not the vehicles)?	YES	NO

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>For Mercy Health Plans use only:</b>	Approved	Length of Approval _____
Denied	Reason for Denial _____	
Reviewer's Signature: _____	Date Reviewed: ____/____/____	
Override Entered in Caremark CCMS for _____ - _____	by _____	
Office Notified on _____	at _____ am/pm	by _____ spoke to _____