



Protopic® (tacrolimus) 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 or high potency topical corticosteroids?	YES	NO
4. Does the patient have a contraindication or allergy to all corticosteroids (not the vehicles)?	YES	NO
5. Is the prescription for Protopic 0.1% ointment?	YES	NO
6. Is the patient 16 years of age or older?	YES	NO

Physician's Signature: _____

Date: ____/____/____

For Mercy Health Plans use only:	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 _____	