Prior Authorization Form
Topical Immunomodulators

INSTRUCTIONS FOR COMPLETING THIS FORM

Please fill out all sections on all pages completely and legibly. If the following information is not complete, correct, or legible, the prior authorization (PA) process can be delayed. Use one form per member, per drug, please. This form, along with other PA forms can be found at: **https://welcome.optumrx.com/tenncare/landing.**

MEMBER INFORMATION

Member Last Name: _____
Member First Name: _____
Member ID: _____
Date of Birth (MM/DD/YYYY): _____ Sex: ☐ Male ☐ Female
Street Address: _____
City: _____ State: _____ ZIP: _____
Phone Number: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____
Prescriber First Name: _____
Prescriber NPI: _____ Prescriber DEA: _____
Specialty: _____ Office Phone: _____ Office Fax: _____
Supervising Physician and DEA (if applicable): _____
Office Street Address: _____
City: _____ State: _____ ZIP: _____
Is the prescriber a single patient contract holder for this patient? ☐ Yes ☐ No
Is the prescriber a TennCare provider with a TN Medicaid ID? ☐ Yes ☐ No

MEDICATION AND DISPENSING INFORMATION

Please refer to the **Preferred Drug List** or see below for Preferred and Non-Preferred Topical Immunomodulators.

With the exception of the "**Branded Drugs to be Classified as Generics List**," TennCare is a mandatory generic program in accordance with state law (TCA 53-10-205). Approval of Non-Preferred agents requires trial and failure, contraindication, or intolerance of two (2) preferred agents, unless otherwise indicated on the **Preferred Drug List (PDL)**.

Antipsoriatics, Topical

Preferred Drugs	Non-Preferred Drugs
calcipotriene cream PA, QL	calcipotriene ointment PA, QL
calcipotriene foam PA, QL	Calcitrene® ointment PA, QL
calcipotriene scalp soln PA	calcitriol ointment PA, QL
Taclonex® PA	calcipotriene/betamethasone PA, QL
tazarotene 0.1% cream PA	Enstilar® PA, QL
	Sorilux® PA, QL
	tazarotene 0.1% gel PA, QL
	Vtama® PA, QL
	Zoryve® 0.3% cream PA, QL

Member Last Name: _____ DOB: _____

Atopic Dermatitis Agents, Topical

Preferred Drugs	Non-Preferred Drugs
Eucrisa® PA, QL	Anzupgo® PA, QL
pimecrolimus QL	Opzelura® PA, QL
tacrolimus QL	Zoryve® 0.15% cream PA, QL

Antiseborrheic Agents

Preferred Drugs	Non-Preferred Drugs
selenium sulfide 2.5% lotion QL	Ovace Plus®
	Ovace Plus Wash®
	selenium sulfide shampoo
	sodium sulfacetamide gel, liquid, shampoo
	sodium sulfacetamide /urea pads
	Zoryve® 0.3% topical foam PA, QL

Drug Name: _____ Drug strength: _____
Drug Formulation: _____ Dosing Frequency: _____
Quantity: _____ Day Supply: _____
Directions for use: _____
Location(s) on body: _____ Duration of treatment: _____

CLINICAL CRITERIA

1. What is the diagnosis?
   - ☐ Atopic dermatitis
   - ☐ Eczema
   - ☐ Chronic Hand Eczema (CHE)
   - ☐ Plaque Psoriasis
   - ☐ Nonsegmental Vitiligo
   - ☐ Seborrheic dermatitis
   - ☐ Other: _____
2. Please provide the ICD-10 code for the diagnosis: _____
3. Has the patient tried any other agents in the past for this condition? ☐ Yes ☐ No
   a. If yes, please list below.
      i. Drug: _____ Dose: _____
      Frequency: _____ Duration: _____
      Result: ☐ Currently taking ☐ Failure/intolerance, reason: _____
      ☐ Contraindication: _____
      ii. Drug: _____ Dose: _____
      Frequency: _____ Duration: _____
      Result: ☐ Currently taking ☐ Failure/intolerance, reason: _____
      ☐ Contraindication: _____
      iii. Drug: _____ Dose: _____
      Frequency: _____ Duration: _____
      Result: ☐ Currently taking ☐ Failure/intolerance, reason: _____
      ☐ Contraindication: _____
4. If the request is for **Opzelura®**, please answer this question.
   a. Is the patient immunocompromised? ☐ Yes ☐ No
   b. Is the patient breastfeeding? ☐ Yes ☐ No
   c. Will Opzelura be used for short-term and/or non-continuous chronic treatment of atopic dermatitis?
      ☐ Yes ☐ No

Question 4 continued on next page.

d. Does the prescriber attest to all of the following? ☐ Yes ☐ No
    i. Patient is not concurrently taking biologic agents (i.e., adalimumab, anakinra, etanercept, rituximab, tocilizumab, infliximab, abatacept) OR potent immunosuppressants (i.e., azathioprine, cyclosporine);
    ii. Benefits of using this agent outweigh the risks of heart-related events (heart attack, stroke, blood clots, etc.) or cardiovascular risk factors.
    iii. Risk of malignancy has been considered, and it has been determined that JAK Kinase inhibitor therapy is appropriate
e. If it is a continuation of therapy, did the patient have a positive response to therapy (e.g. reduction in symptoms (itch, rash), re-pigmentation? ☐ Yes ☐ No

5. If the request is for **Zoryve®**, please answer this question.
    a. Does the patient have moderate to severe liver impairment (Child-Pugh B or C)? ☐ Yes ☐ No
    b. If it is a continuation of therapy, did the patient have a positive response to therapy (e.g. reduction in itch, rash, inflammation)? ☐ Yes ☐ No
6. If the request is for **Vtama®**, please answer this question.
    a. If it is a continuation of therapy, did the patient have a positive clinical response to therapy as evidenced by one of the following?
        i. Reduction in the body surface area (BSA) involvement from baseline ☐ Yes ☐ No
        ii. Improvement in symptoms (e.g., pruritic, inflammation) from baseline ☐ Yes ☐ No

    Note: Please submit documentation to support the positive clinical response.
7. If the request is for **Anzupgo®**, please answer this question.
    a. Is the patient taking other Janus kinase (JAK) inhibitors? ☐ Yes ☐ No
    b. Is the patient taking any other potent immunosuppressants (e.g., azathioprine, cyclosporine)? ☐ Yes ☐ No
8. Please include any other information pertinent to this request: _____

PRESCRIBER SIGNATURE

By signature, the prescriber confirms the above information is accurate and verifiable by patient records.

Prescriber Signature: _____ Date: _____

INSTRUCTIONS FOR SUBMISSION

PA requests can be submitted to Optum Rx via fax (866-434-5523), by phone (866-434-5524), or by electronic PA request, such as CoverMyMeds. For questions, please call 1-866-434-5524. Optum Rx will provide a response within 24 hours upon receipt.