



Neffy® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Moderate to severe chronic hand eczema (CHE)	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
Clinical information:	
Provide medical necessity and/or a documented contraindication indicating that the patient is unable to use an epinephrine auto-injector:	

Quantity limit requests:	
What is the quantity requested per TREATMENT? _____ every _____ weeks	
What is the reason for exceeding the plan limitations?	
<input type="checkbox"/> Titration or loading dose purposes	
<input type="checkbox"/> Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)	
<input type="checkbox"/> Requested strength/dose is not commercially available	
<input type="checkbox"/> Other: _____	

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.