MC-Rx
Powered by ProCare Rx

Protopic® tacrolimus

Ticket #: _____ **Request Date:** _____ **Request Time:** _____

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of **Protopic®** tacrolimus. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information		
Patient Name:	Plan Name/Plan ID:	
Patient ID:	Patient Date of Birth:	Patient Contact Phone #:

B. Physician Information			
Physician Name:	Physician Address:		
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC #:

C. Pharmacy Information			
Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:

D. Clinical Information (Please fill out the following information: circle all that apply)

Diagnosis:

1. Is the patient at least 2 years of age? (for the **0.03% Ointment**) YES NO
2. Is the patient at least 15 years of age? (for the **0.1% Ointment**) YES NO
3. Has the patient been diagnosed with **moderate to severe atopic dermatitis**? YES NO
4. Has the patient failed therapy or received inadequate responses with at least two topical corticosteroids? YES NO
5. Is the patient intolerant or unable to use topical steroid therapies? YES NO

RENEWAL PA ONLY:

1. Does the patient have persistent symptoms? YES NO
2. Has the patient been re-evaluated for continuation of therapy? YES NO

Dosing Guidelines:
Adults: (0.03% and 0.1%) Apply a thin layer to the affected skin areas BID and rub in gently and completely. Continue treatment for 1week after clearing of signs and symptoms of atopic dermatitis.
Children: (0.03% only) Apply a thin layer to the affected skin areas BID and rub in gently and completely. Continue treatment for 1 week after clearing of signs and symptoms of atopic dermatitis.

Authorized Medical Signature:	
Telephone:	**Date:**

When Completed Return To:

MC-Rx Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.