AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Eucrisa® (crisaborole) 2% **ointment**

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

Quantity Limit: 1 tube per 30 days

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied. Check box below for the Diagnosis that applies.

- ❑ Member is ≥ 3 months of age
- ❑ Member has a diagnosis of atopic dermatitis for ≥ 3 months
- ❑ Member has tried and failed **BOTH** of the following **(verified by chart notes and pharmacy paid claims)**:
  - ❑ At least 14 days of therapy with a topical corticosteroid **(e.g., triamcinolone, mometasone, fluocinolone, fluocinonide, betamethasone)**
  - ❑ At least 30 days of therapy with a topical calcineurin inhibitor **(e.g., tacrolimus ointment, pimecrolimus cream)**

(Continued on next page)

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

***Approved by Pharmacy and Therapeutics Committee:** ~~6/15/2017;~~ **9/26/2024**
REVISED/UPDATED/REFORMATTED: ~~9/28/2017; 6/10/2019; 2/21/2022; 3/11/2022; 3/23/2022; 10/15/2024;~~ **2/20/2025**