



Elidel® (pimecrolimus) Prior Authorization Request Form

Please fax the completed request form to the Coventry Health Care Pharmacy Department at 877-815-8751. For additional information call 800-647-2240.

Patient Name: _____ Today's Date: ____/____/____
 Patient Pharmacy ID: _____ Date of Birth: ____/____/____
(located on bottom right of insurance card)
 Requesting Physician: _____ Specialty: _____
(Please print)
 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-to-high potency corticosteroids?	YES	NO
4. Does the patient have a contraindication or allergy to all corticosteroids (not the vehicles)?	YES	NO

Physician's Signature: _____ Date: ____/____/____

For Mercy Health Plans use only:	<input type="checkbox"/> Approved	Length of Approval _____
<input type="checkbox"/> Denied	Reason for Denial _____	
Reviewer's Signature: _____	Date Reviewed: ____/____/____	
Override Entered in <input type="checkbox"/> Caremark <input type="checkbox"/> CCMS for _____	by _____	
Office Notified on _____	; at _____ am/pm; by _____ spoke to _____	