



Protopic® (tacrolimus) 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 or high potency topical corticosteroids?	YES	NO
4. Does the patient have a contraindication or allergy to all corticosteroids (not the vehicles)?	YES	NO
5. Is the prescription for Protopic 0.1% ointment?	YES	NO
6. Is the patient 16 years of age or older?	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 _____		