Updated: 01/2025
DMMA Approved: 02/2025

Request for Prior Authorization for Topical Immunomodulators
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Topical Immunomodulators require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Topical Immunomodulators include Protopic (tacrolimus), Elidel (pimecrolimus), Eucrisa (crisaborole), Zoryve (roflumilast), and Opzelura (ruxolitinib). New products with this classification will require the same documentation.

Prior Authorization Criteria:

For all requests, the following criteria must be met:

- Is prescribed for an FDA-approved or medically accepted indication
- Must be age-appropriate according to FDA-approved labeling, nationally recognized compendia, or evidence-based practice guidelines
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- For non-preferred agents, must have a therapeutic failure, contraindication, or intolerance to the preferred agent(s) approved or medically accepted for the member's diagnosis
- For a topical calcineurin inhibitor [i.e.Protopic (tacrolimus) and Elidel (pimecrolimus)], must have tried and failed or had an intolerance or contraindication to a topical corticosteroid.
- For a topical PDE4 inhibitor [i.e. Eucrisa (crisaborole), Zoryve (roflumilast)], must have tried and failed ONE of the following or had an intolerance or contraindication to both:
    - Topical corticosteroid
    - Topical calcineurin inhibitor
- For a topical JAK inhibitor [i.e. Opzelura (ruxolitinib)], must have tried and failed or had an intolerance to BOTH of the following:
    - Topical corticosteroid
    - Topical calcineurin inhibitor
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
    - Documentation of improvement in condition and tolerance to therapy
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

HIGHMARK HEALTH OPTIONS

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TOPICAL IMMUNOMODULATORS PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (855) 476-4158**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon – Fri 8 am to 7 pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis:	ICD Code:

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced an improvement with treatment? ☐ Yes ☐ No

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date