Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Immunomodulators (Atopic Dermatitis) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 1 year (Exception: Dupixent: 6 months); Continuation- 1 year

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Immunomodulators (Atopic Dermatitis).** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at: http://pithelp.appl.kp.org/MAS/formulary.html**

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Provider Information

Provider Name: _____ Provider NPI: _____

Provider Address: _____

Provider Phone #: _____Provider Fax #: _____

Please check the boxes that apply:

□Initial Request □ Continuation of Therapy Request

□ Standard Review (72 hours)

□ Expedited Review (24 hours): By checking this box, I certify that applying 72 hours standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Provider Signature_____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____

Sig: _____

Drug 2: Name/Strength/Formulation: _____

Sig: _____

5 – Diagnosis

Diagnosis of Atopic Dermatitis? □No □ Yes
Severity: □ Mild □ Moderate □ Severe

6 – Clinical Criteria

Initial Criteria for Elidel, Eucrisa, Protopic, and tacrolimus:

□ Elidel and Eucrisa: Mild to Moderate for ages > 2 years old
□ Protopic 0.03%: Moderate to Severe for ages >2 years old
□ Protopic 0.1%: Moderate to Severe for ages >18 years old

AND

Documented trial and failure (or contraindication) of:

□ 1 Topical corticosteroid (i.e. desonide, hydrocortisone butyrate)
Dates and Outcome: _____

Criteria for Dupixent:

□ Moderate to Severe for ages ≥ 18 years old (**contraindicated in pregnancy**)

AND

At least ≥ 1 of the following (Note: After Treatment is for Continuation of Therapy Requests only):

□ Involvement of at least 10% of body surface area (BSA)
BSA Involvement: Before Treatment: _____ After Treatment: _____
□ Scoring Atopic Dermatitis (SCORAD) score of ≥ 20
SCORAD Score: Before Treatment: _____ After Treatment: _____
□ Investigator's Global Assessment (IGA) score of ≥ 3
IGA Score: Before Treatment: _____ After Treatment: _____
□ Eczema Area and Severity Index (EASI) score of ≥ 16
EASI Score: Before Treatment: _____ After Treatment: _____
□ Incapacitation due to atopic dermatitis lesion location (i.e. head and neck, palms, soles, or genitalia)
Incapacitation: Before Treatment: _____ After Treatment: _____

AND

Documented trial and failure (or contraindication) of:

□ 1 topical corticosteroid of Medium to High potency (i.e. mometasone, fluocinolone)
Dates and Outcome: _____
□ 1 topical calcineurin inhibitor (i.e. tacrolimus or pimecrolimus)
Dates and Outcome: _____
□ 1 immunosuppressive systemic agent for at minimum 3 months (i.e. cyclosporine, azathioprine, methotrexate)
Dates and Outcome: _____
□ Phototherapy for at minimum 3 months (i.e. Psoralens with UVA [PUVA], UVB)
Dates and Outcome: _____

7 – Provider Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration.

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	**Date:**