

TOPICAL DOXEPIN PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today's Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis: <input type="checkbox"/> Moderate pruritus associated with atopic dermatitis <input type="checkbox"/> Moderate pruritus associated with lichen simplex chronicus <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

- Is the patient currently using the requested agent? Yes No
 If yes, is the patient currently stable on the requested agent? **Please note, chart notes are required.** Yes No
- Does the patient have any FDA labeled contraindications to the requested agent? Yes No
 If yes, please specify FDA labeled contraindications: _____
- Will the patient be using the requested agent in combination with another topical doxepin agent? Yes No
- Has the patient already received 8 days of therapy with a topical doxepin agent for the current course of therapy? Yes No
- Is the patient's age within FDA labeling for the requested indication for the requested agent? Yes No
 If no, please provide support for using the requested agent for the patient's age for the requested indication: _____
- Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max): _____

For moderate pruritus associated with lichen simplex chronicus requests:

- Has the patient tried and had an inadequate response to ONE topical corticosteroid? Yes No
 If no, does the have an intolerance or hypersensitivity to ONE topical corticosteroid? Yes No
 If yes, please explain intolerance/hypersensitivity: _____

 If no, does the patient have an FDA labeled contraindication to ALL topical corticosteroids? Yes No
 If yes, please specify FDA labeled contraindication: _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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For moderate pruritus associated with atopic dermatitis requests:

8. Has the patient tried and had an inadequate response to ONE topical corticosteroid used in the treatment of AD after at least a 4-week duration of therapy? Yes No
 If no, does the patient have an intolerance or hypersensitivity to ONE topical corticosteroid used in the treatment of AD? Yes No
 If yes, please explain intolerance/hypersensitivity: _____
- If no, does the patient have an FDA labeled contraindication to ALL topical corticosteroids used in the treatment of AD? Yes No
 If yes, please specify FDA labeled contraindication: _____
9. Has the patient tried and had an inadequate response to ONE topical calcineurin inhibitor used in the treatment of AD after at least a 6-week duration of therapy? Yes No
 If no, Does the patient have an intolerance or hypersensitivity to ONE topical calcineurin inhibitor used in the treatment of AD? Yes No
 If yes, please explain intolerance/hypersensitivity: _____
- If no, does the patient have an FDA labeled contraindication to ALL topical calcineurin inhibitors used in the treatment of AD? Yes No
 If yes, please specify FDA labeled contraindication: _____
10. Is the patient currently treated with topical emollients and practicing good skin care? Yes No
 If yes, will the patient continue the use of topical emollients and good skin care practices in combination with the requested agent? Yes No

For brand Prudoxin cream and brand Zonalon cream requests, please provide chart notes to support the answers to the following questions:

11. Has the patient tried and had an inadequate response to generic doxepin hydrochloride cream 5%? Yes No
 12. Was generic doxepin hydrochloride cream 5% discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
 13. Does the patient have an intolerance or hypersensitivity to generic doxepin hydrochloride cream 5% that is not expected to occur with the brand agent? Yes No
 14. Does the patient have an FDA labeled contraindication to generic doxepin hydrochloride cream 5% that is not expected to occur with the brand agent? Yes No
 15. Is generic doxepin hydrochloride cream 5% expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? Yes No
 16. Is generic doxepin hydrochloride cream 5% not in the best interest of the patient based on medical necessity? Yes No
 17. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as generic doxepin hydrochloride cream 5% and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
 18. Is there support for the use of the requested brand agent over generic doxepin hydrochloride cream 5%? Yes No
 If yes, please provide supporting information: _____

Please fax or mail this form to:
 Prime Therapeutics LLC
 Clinical Review Department
 2900 Ames Crossing Road Suite 200
 Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
BCBSIL: 800.285.9426
BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

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