US Family Health Plan
Prior Authorization Request Form
for Crisaborole **(Eucrisa)**

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **617-562-5296**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth _____ Secure Fax #: _____

Step 2 **Please complete the clinical assessment:**

1. Does the patient have a diagnosis of mild to moderate atopic dermatitis?	☐ **Yes** **Proceed to question 2**	☐ **No** **STOP** **Coverage not approved**
2. Is the requested medication being prescribed by an Allergist, Immunologist or Dermatologist?	☐ **Yes** **Proceed to question 3**	☐ **No** **STOP** **Coverage not approved**
3. Does the patient have a contraindication to, intolerability to, or failed treatment with, a two week trial of at least one medium to high potency topical corticosteroid?	☐ **Yes** **Proceed to question 4**	☐ **No** **STOP** **Coverage not approved**
4. Does the patient have a contraindication to, intolerability to, or failed treatment with, a two week trial of a second agent including one of the following: 1) an additional medium - high potency topical corticosteroid OR 2) topical calcineurin inhibitor (such as tacrolimus, Elidel)?	☐ **Yes** **Sign and date below**	☐ **No** **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date.

_____ _____
Prescriber Signature Date

[14 February 2018]