PRIOR AUTHORIZATION REQUEST

ANZUPGO

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Will the requested medication be used in combination with biologics (Dupixent, Adbry, etc.), Janus kinase (JAK) inhibitors (Opzelura, Xeljanz, Rinvoq, etc.), or potent immune suppressing agents (azathioprine, cyclosporine)? [If yes, no further questions.]	Yes	No
2	Is this request for an INITIAL or CONTINUATION of therapy? [] Initial (If checked, go to 8)		

If you have any questions, call: 1-888-258-8250

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	[] Continuation (If checked, go to 3)		
3	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No
4	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 8.]	Yes	No
5	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [NOTE: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 8.]	Yes	No
6	Has the patient been on established therapy for at least 3 months? [If no, skip to question 8.]	Yes	No
7	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the prescriber? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
8	What is the indication or diagnosis? ACTION REQUIRED: Submit supporting documentation. [] Mild chronic hand eczema (If checked, no further questions) [] Moderate to severe chronic hand eczema (If checked, go to 9) [] All other indications or diagnoses (If checked, no further questions)		
9	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
10	Has the patient had eczema of the hands for 3 months or longer? ACTION REQUIRED: Submit supporting documentation. [If yes, skip to question 12.]	Yes	No
11	Has the patient had eczema of the hands that has reoccurred two or more times within a 12-month time frame after its initial presentation and subsequent clearance? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
12	Has documentation been submitted to confirm that the patient has an intolerance, contraindication to, or failed treatment with at least TWO medium-, medium-high, high-, and/or super- high potent prescription topical corticosteroids? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
13	Has the patient had a trial and failure, intolerance to, or contraindication to a topical calcineurin inhibitor (pimecrolimus or tacrolimus) for at least 28 consecutive days? [If no, no further questions.]	Yes	No

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14	Has documentation been submitted to confirm that the patient has had a treatment failure with Zoryve (roflumilast) for at least 28 days, or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
15	Has documentation been submitted to confirm that the patient has had a treatment failure with Opzelura (ruxolitinib) for at least 28 days, or is the patient intolerant or the medication contraindicated? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
16	Does the provider attest that the patient's eczema is limited to their hands and Anzupgo will only be applied to the hands or wrist? [If no, no further questions.]	Yes	No
17	Is the requested medication being prescribed by or in consultation with an allergist, immunologist, or dermatologist?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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