Prescriber Criteria Form Protopic 2025 PA Fax 1449-A v1 010125.docx Protopic (tacrolimus) Coverage Determination
This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Protopic (tacrolimus).

Drug Name: Protopic (tacrolimus)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is the request for Protopic (tacrolimus) 0.1 percent ointment? [If no, then skip to question 3.]	Yes ◯	No ◯
2	Is the patient 16 years of age or older? [If yes, then skip to question 4.] [If no, then no further questions.]	Yes ◯	No ◯
3	Is the patient 2 years of age or older? [If no, then no further questions.]	Yes ◯	No ◯
4	Is the requested drug being prescribed for the short-term or non-continuous chronic treatment of moderate to severe atopic dermatitis (eczema)? [If no, then skip to question 7.]	Yes ◯	No ◯
5	Will the requested drug be used on sensitive skin areas (e.g. face, genitals, or skin folds)? [If yes, then no further questions.]	Yes ◯	No ◯
6	Has the patient experienced an inadequate treatment response, intolerance, or contraindication to at least one first line therapy agent (e.g., medium or higher potency topical corticosteroid)? [No further questions.]	Yes ◯	No ◯

7	Is the requested drug being prescribed for the short-term or non-continuous chronic treatment of psoriasis on the face, genitals, or skin folds?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ **Date:**_____