GHP Family Pharmacy Customer Service
100 N. Academy Ave.
Danville, PA 17822
Tel. • 855•552•6028 PA Relay 711 GeisingerHealthPlan.com

Geisinger

IMMUNOMODULATORS, ATOPIC DERMATITIS PRIOR AUTHORIZATION FORM *(form effective 1/8/2024)*

Prior authorization guidelines for **Immunomodulators, Atopic Dermatitis** and **Quantity Limits/Daily Dose Limits** are available on Geisinger Health Plan's website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:	Dosage form:	
Directions:		Quantity:	Refills:
Diagnosis (*submit documentation*):		Diagnosis code (*required*):	

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

INITIAL requests

1. For a non-preferred topical calcineurin inhibitor:

☐Tried and failed or has a contraindication or an intolerance to the preferred topical calcineurin inhibitors *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

2. For a topical JAK inhibitor (eg, Opzelura [ruxolitinib]) OR a topical PDE4 inhibitor (eg, Eucrisa [crisaborole]):

☐Tried and failed or has a contraindication or an intolerance to a 4-week trial of a topical corticosteroid approved or medically accepted for the beneficiary's diagnosis

☐Tried and failed or has a contraindication or an intolerance to an 8-week trial of a topical calcineurin inhibitor (eg, pimecrolimus, tacrolimus) approved or medically accepted for the beneficiary's diagnosis

3. For all other non-preferred TOPICAL Immunomodulators, Atopic Dermatitis:

☐Tried and failed or has a contraindication or an intolerance to the preferred topical Immunomodulators, Atopic Dermatitis approved or medically accepted for the beneficiary's diagnosis *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

4. For a targeted systemic Immunomodulator, Atopic Dermatitis (eg, Adbry, Cibinqo, Rinvoq):

☐Is prescribed the medication by or in consultation with an appropriate specialist (eg, dermatologist)

☐**For the treatment of atopic dermatitis:** Tried and failed or has a contraindication or an intolerance to both of the following (*check all that apply):*

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☐ One of the following:
  ☐ For the face, skin folds, or other critical areas, a 4-week trial of a low-potency (or higher) topical corticosteroid
  ☐ For other body areas, a 4-week trial of a medium potency or higher topical corticosteroid
☐ An 8-week trial of a topical calcineurin inhibitor (eg, pimecrolimus, tacrolimus)

☐ **For the treatment of all other diagnoses – specify diagnosis:** _____

☐ List other treatments tried (including start/stop dates, dose, outcomes, etc.): _____

_____

☐ **For an oral JAK inhibitor (eg, Cibinqo, Rinvoq):**
☐ Tried and failed at least one biologic as recommended in the JAK inhibitor's package labeling
☐ Has a contraindication or an intolerance to biologics as recommended in the JAK inhibitor's package labeling
☐ Is currently taking an oral JAK inhibitor

☐ **For a NON-PREFERRED targeted systemic Immunomodulator, Atopic Dermatitis:**
☐ Tried and failed or has a contraindication or intolerance to the preferred targeted systemic Immunomodulators, Atopic Dermatitis approved or medically accepted for the beneficiary's condition *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*
☐ Is currently using the requested non-preferred targeted systemic Immunomodulator, Atopic Dermatitis

- What is the date of the beneficiary's last dose? _____

RENEWAL requests

1. For a non-preferred topical calcineurin inhibitor:
☐ Has documented evidence of improvement of disease severity
☐ Tried and failed or has a contraindication or an intolerance to the preferred topical calcineurin inhibitors *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

2. For a topical JAK inhibitor (eg, Opzelura [ruxolitinib]) OR a topical PDE4 inhibitor (eg, Eucrisa [crisaborole]):
☐ Has documented evidence of improvement of disease severity

3. For all other non-preferred TOPICAL Immunomodulators, Atopic Dermatitis:
☐ Has documented evidence of improvement of disease severity
☐ Tried and failed or has a contraindication or an intolerance to the preferred topical Immunomodulators, Atopic Dermatitis approved or medically accepted for the beneficiary's diagnosis *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

4. For a targeted systemic Immunomodulator, Atopic Dermatitis (eg, Adbry, Cibinqo, Rinvoq):
☐ Has documented evidence of improvement of disease severity
☐ Is prescribed the medication by or in consultation with an appropriate specialist (eg, dermatologist)

Please submit to PromptPA https://ghp.promptpa.com OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature:	**Date**:

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