IMMUNOMODULATORS, DERMATOLOGICS PRIOR AUTHORIZATION FORM *(form effective 1/5/2026)*

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

Prior authorization guidelines for **Immunomodulators, Dermatologics** and **Quantity Limits/Daily Dose Limits** are available on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html.

☐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:	
Member name:		City/state/zip:	
Member 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 member 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 PDE4 INHIBITOR (eg, Eucrisa, Zoryve):

☐**For the treatment of ATOPIC DERMATITIS,** tried and failed or cannot try (due to a contraindication or an intolerance) to BOTH of the following:
- ☐A 4-week trial of a topical corticosteroid
- ☐An 8-week trial of a topical calcineurin inhibitor (eg, pimecrolimus, tacrolimus)

☐**For the treatment of all other diagnoses,** list other treatments tried (including start/stop dates, dose, outcomes, etc.):

_____

3. For a TOPICAL JAK INHIBITOR (eg, Opzelura):

☐**For the treatment of ATOPIC DERMATITIS,** tried and failed or cannot try (due to a contraindication or an intolerance) to BOTH of the following:

☐ A 4-week trial of a topical corticosteroid
☐ An 8-week trial of a topical calcineurin inhibitor (eg, pimecrolimus, tacrolimus)

☐ **For the treatment of CHRONIC HAND ECZEMA,** tried and failed or cannot try (due to a contraindication or an intolerance) to BOTH of the following:
☐ A 4-week trial of a topical corticosteroid
☐ An 8-week trial of a topical calcineurin inhibitor (eg, pimecrolimus, tacrolimus)

☐ **For the treatment of VITILIGO,** tried and failed or cannot try (due to a contraindication or an intolerance) to BOTH of the following:
☐ A 4-week trial of a topical corticosteroid
☐ An 8-week trial of a topical calcineurin inhibitor (eg, pimecrolimus, tacrolimus)

☐ **For the treatment of ALL OTHER diagnoses,** list other treatments tried (including start/stop dates, dose, outcomes, etc.):

_____

4. For a TOPICAL AhR AGONIST (eg, Vtama):

☐ **For the treatment of ATOPIC DERMATITIS,** tried and failed or cannot try (due to a contraindication or an intolerance) to BOTH of the following:
☐ A 4-week trial of a topical corticosteroid
☐ An 8-week trial of a topical calcineurin inhibitor (eg, pimecrolimus, tacrolimus)

☐ **For the treatment of ALL OTHER diagnoses,** list other treatments tried (including start/stop dates, dose, outcomes, etc.):

_____

5. For all other NON-PREFERRED TOPICAL Immunomodulators, Dermatologics:

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

6. For a TARGETED SYSTEMIC Immunomodulator, Dermatologics (eg, Adbry, Cibinqo, Rinvoq):

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

☐ **For the treatment of ATOPIC DERMATITIS:**
☐ Has at least ONE of the following:
☐ A BSA of ≥10% that is affected
☐ Involvement of critical areas (e.g., face, feet, genitals, hands, intertriginous areas, scalp)
☐ Significant disability or impairment of physical, mental, or psychosocial functioning
☐ Tried and failed or cannot try (due to a contraindication or an intolerance) to BOTH of the following:
☐ A 4-week trial of a topical corticosteroid
☐ An 8-week trial of a topical calcineurin inhibitor (eg, pimecrolimus, tacrolimus)

☐ **For treatment of PRURIGO NODULARIS (PN):**
☐ Has a history of pruritis for at least 6 weeks
☐ Has PN associated with at least ONE of the following:
☐ ≥20 nodular lesions
☐ Significant disability or impairment of physical, mental, or psychosocial functioning

☐ **For the treatment of ALL OTHER diagnoses,** 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, Dermatologics:**
☐ Tried and failed or has a contraindication or intolerance to the preferred targeted systemic Immunomodulators, Dermatologics *(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, Dermatologics

- What is the date of the member'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 PDE4 INHIBITOR (eg, Eucrisa, Zoryve):

☐ Has documented evidence of improvement of disease severity

3. For a TOPICAL JAK INHIBITOR (eg, Opzelura):

☐ Has documented evidence of improvement of disease severity

4. For a TOPICAL AhR AGONIST (eg, Vtama):

☐ Has documented evidence of improvement of disease severity

5. For all other NON-PREFERRED TOPICAL Immunomodulators, Dermatologics:

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

6. For a TARGETED SYSTEMIC Immunomodulator, Dermatologics (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 FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO 844-205-3386

Prescriber Signature:	**Date**:

Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)