Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Topical Anti-Inflammatories

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
3. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: _____ 2. Strength: _____ 3. Quantity Per 30 Days: _____
4. Length of Therapy (in Days): ☐ up to 30 Days ☐ 60 Days ☐ 90 Days ☐ 120 Days ☐ 180 Days ☐ 365 Days ☐ Other _____

Clinical Information

1. Has the member tried and failed on at least one prescription topical corticosteroid? ☐ **Yes** ☐ **No**
2. Does the member have a documented adverse reaction or contraindication that precludes trial of 1 topical corticosteroid? ☐ **Yes** ☐ **No** Please List: _____

For Non-preferred medication Requests:

3. Has the member tried and failed any preferred topical anti-inflammatory medications? ☐ **Yes** ☐ **No**
4. Please list any failed medications or contraindications: _____

Please answer the following depending on the Topical Anti-inflammatory being requested:

5. Eucrisa: Is the member 3 months old or older? ☐ **Yes** ☐ **No**
6. Elidel, Pimecrolimus cream, Protopic 0.03%, and Tacrolimus 0.03%: Is the member 2 years of age or older? ☐ **Yes** ☐ **No**
7. Protopic 0.1% and Tacrolimus 0.1%: Is the member 18 years of age or older? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.