Neighborhood Health Plan

Prior Authorization Request Form – Topical Corticosteroid Medications

Instructions:

This form is to be used by participating providers to request coverage for topical corticosteroid medications requiring prior authorization. Please fill out this form COMPLETELY, including signature, and fax to MedMetrics Health Partners at 1-800-918-7542. Allow 24 hours to process request. Please call MedMetrics PA Line (available 24 hours a day) at 1-800-918-7550 for more urgent requests.

MedMetrics Health Partners – Prior Authorization Services
P. O. Box 2586, Worcester, MA 01606

Phone: 1-800-918-7550
Fax: 1-800-918-7542

A topical corticosteroid step therapy program has been developed to encourage the use of first-line therapies before second-line therapies are used for the same indication.

First-line therapies include: aclometasone, amcinonide, augmented betamethasone dipropionate, betamethasone dipropionate, betamethasone valerate, clobetasol propionate, desonide, desoximetasone, diflorasone, fluocinolone, fluocinonide, fluticasone, halobetasol, hydrocortisone, hydrocortisone butyrate, hydrocortisone valerate, mometasone, triamcinolone, and prednicarbate.

Please PRINT and complete ALL of the following boxes:

1. Member's FULL Name:	2. Member's NHP ID Number:	3. Member's DOB: (mm/dd/yy)

4. Prescriber's FULL Name and Specialty: Mailing Address:	5. Contact Person at Office:

Prescriber's FAX and Telephone Number: Fax: ( ) Tel: ( )

7. Requested Drug:

- ☐ Apexicon E 0.05% cream,
- ☐ Capex 0.01% shampoo
- ☐ Clobex 0.05%: __lotion, __shampoo, __liquid
- ☐ Cloderm 0.1% cream
- ☐ Cordran 0.05%: __cream, __lotion
- ☐ Cordran 4mcg/cm^2 tape
- ☐ Cutivate 0.05% lotion
- ☐ Derma-Smoothe/FS 0.01% oil
- ☐ Halog 0.1%: __cream, __ointment
- ☐ Kenalog-A solution
- ☐ Locoid 0.1% lotion
- ☐ Luxiq 0.12% foam
- ☐ Olux-E 0.05% foam
- ☐ Pandel 0.1% cream
- ☐ Texacort 2.5% Solution
- ☐ Vanos 0.1% cream
- ☐ Verdeso 0.05% foam
- ☐ Other: _____

8. Has the member tried at least **four** of the following generic products **within the past 180 days**?

Drug Name and Response(please check all that apply)			
☐ aclometasone	☐ side-effect ☐ no response ☐ allergy	☐ fluocinolone acetonide	☐ side-effect ☐ no response ☐ allergy
☐ amcinonide	☐ side-effect ☐ no response ☐ allergy	☐ fluticasone propionate	☐ side-effect ☐ no response ☐ allergy
☐ betamethasone	☐ side-effect ☐ no response ☐ allergy	☐ halobetasol propionate	☐ side-effect ☐ no response ☐ allergy
☐ clobetasol propionate	☐ side-effect ☐ no response ☐ allergy	☐ hydrocortisone	☐ side-effect ☐ no response ☐ allergy
☐ desonide	☐ side-effect ☐ no response ☐ allergy	☐ mometasone furoate	☐ side-effect ☐ no response ☐ allergy
☐ desoximetasone	☐ side-effect ☐ no response ☐ allergy	☐ triamcinolone acetonide	☐ side-effect ☐ no response ☐ allergy
☐ diflorasone	☐ side-effect ☐ no response ☐ allergy	☐ prednicarbate	☐ side-effect ☐ no response ☐ allergy
☐ fluocinonide	☐ side-effect ☐ no response ☐ allergy	☐ other: _____	☐ side-effect ☐ no response ☐ allergy

9. Prescriber comments:

Signature:

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.

Prescriber's signature Date