



Elidel – pimecrolimus

Member Information

Name _____
Enrollment / Cardholder ID _____
Group / Plan _____
Birth Date _____
Address _____
City State Zip _____

Relationship (Circle)

Subscriber Spouse Dependent
Gender (Circle)
Male Female
AGE: _____

Practitioner Information

Name _____
Agent / Contact Name _____
Specialty _____
Office / Clinic Name _____
Address _____
City State Zip _____
Phone () - _____
Fax () - _____
Email _____ @ _____

**Primary Diagnosis Condition /
Diagnosis Related – Reason for Request**

- Does the patient have atopic dermatitis? **Y / N**
- Please indicate disease severity: Mild Moderate Severe
- Has the patient tried a topical corticosteroid? **Y / N**
- If yes, please list the medication(s), strength, and dates of therapy:

- Does the patient have a contraindication to therapy with a topical corticosteroid? **Y / N**
- If yes, please define: _____
- Does the patient have a weakened or compromised immune system? **Y / N**
- If yes, please explain: _____

Strength / Dose / Frequency

Duration of Therapy (Expected)

Surface area(s) to be treated and % of BSA

**Formulary Alternatives
Attempted/Outcome**

Clinical Drug / Lab History Pertinent to Request

Contact Pharmacy? **Y** **N**
Pharmacy Phone Number

Practitioner Signature

Date Received: _____
Reviewed By: _____
Forwarded To: _____

**FAX Form to
877-800-5633**