NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

WellCare
Beyond Healthcare. A Better You.

Eucrisa Temporary PA Request Form

Beneficiary Information

1. Beneficiary Last Name:_____ 2. First Name:_____

3. Beneficiary ID #:_____4. Beneficiary Date of Birth:_____ 5. Recipient Gender:_____

Prescriber Information

6. Prescribing Provider NPI#:_____

7. Requester Contact Information: Name:_____ Phone #: _____Ext:_____

Drug Information

8. Med requested: **Eucrisa** 9a. Strength: _____ 9b. Quantity per 30 days _____

9c. Requested Duration _____

10. For areas OTHER than groin or face: Has the patient failed 2 generic topical corticosteroids in the highest potency class and is the patient greater than 2 years of age? **Yes**_____ **No**_____

11. For groin and face: Has the patient failed 2 topical generic corticosteroids from preferred list in any potency class (see criteria for list) AND is patient greater than 2 years of age? Yes_____ No_____

12. Does the patient have a documented adverse reaction or contraindication that precludes trial of 2 generic topical corticosteroids from preferred list (see criteria for list)? **Yes**_____ **No**_____
Please list: _____

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.

Fax this form to: **(800) 678-3189** Pharmacy PA Call Center: **(866) 799-5318**