Nevada Medicaid – Molina Healthcare
Protopic® (tacrolimus) Prior Authorization Request Form

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request. **Please FAX responses to: (844) 259-1689. Phone: (833) 685-2103.**

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Molina ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Moderate to severe atopic dermatitis

❑ Other diagnosis:_____ICD-10 Code(s): _____

Clinical information:

Will the requested medication be used chronically? ☐ **Yes** ☐ **No**

Is the member immunocompromised? ☐ **Yes** ☐ **No**

For tacrolimus (generic for Protopic) requests, also answer the following:

Has the member experienced a side effect, allergy, or treatment failure with the brand formulation of the requested medication? ☐ **Yes** ☐ **No**

Has the member experienced therapeutic failure of TWO preferred medications within the same drug class? ☐ **Yes** ☐ **No**

If **yes**, list ALL medications: _____

Does the member have an allergy, contraindication, drug-to-drug interaction, or a history of unacceptable/toxic side effects with ALL preferred medications within the same drug class? ☐ **Yes** ☐ **No**

If **yes**, list ALL medications & allergy/contraindication/interaction/side effects:_____

_____

Is the non-preferred medication being requested because it is being used for a unique indication that is supported by peer-reviewed literature or an FDA-approved indication? ☐ **Yes** ☐ **No**

If **yes**, list the unique indications: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call (833) 685-2103.
This form may be used for non-urgent requests and faxed to (844) 259-1689.