CAREFIRST - CITY OF BALTIMORE
Prudoxin, Zonalon Step Therapy

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Prudoxin, Zonalon Step Therapy .

Patient Information

Patient Name:

Patient Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Patient ID:

Patient Group No:

Patient DOB: ☐☐ / ☐☐ / ☐☐☐☐

Prescribing Physician

Physician Name:

Physician Phone: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Fax: ☐☐☐ - ☐☐☐ - ☐☐☐☐

Physician Address:

City, State, Zip:

Drug Name (select from list of drugs shown)

Doxepin 5% Cream Prudoxin (doxepin 5% cream) Zonalon (doxepin 5% cream)

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

_____

_____

Please check the appropriate answer for each applicable question.

1. Is the requested drug being prescribed for the management of moderate pruritus in an adult patient with atopic dermatitis or lichen simplex chronicus? **Y** ☐ **N** ☐
2. Is the requested drug being prescribed for short-term use (up to 8 days)? **Y** ☐ **N** ☐
3. Has the patient experienced an inadequate response to any of the following: A) topical corticosteroid, B) topical tacrolimus (Protopic), C) pimecrolimus (Elidel), D) Eucrisa (crisaborole)? **Y** ☐ **N** ☐
4. Does the patient require more than the plan allowance of 90 grams per month? **Y** ☐ **N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date

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