

**Community Care of Wake & Johnston Counties
MD Easy™ Form – Topical Anti-inflammatory Medications**

This form MUST BE FAXED to the PHARMACY

Practice Information		Patient Information	
Practice Name		Patient Name	
Practice Address		Patient Address	
Practice City, State, Zip		Patient City, State, Zip	
Practice Phone	Practice Fax	Date of Birth	Medicaid ID
Pharmacy Information		Originally Prescribed Topical Anti-inflammatory	
Pharmacy Name		Drug Name/Strength	
Pharmacy Phone	Pharmacy Fax	Last Filled	Quantity

Topical Anti-inflammatory Prior Authorization Criteria

Criteria for coverage of Elidel and Protopic 0.03%:

- For areas other than groin or face, failed 2 generic topical corticosteroids in highest potency class and patient is greater than 2 years of age.
 - For groin and face failed 2 topical generic corticosteroids from preferred list in any potency class and patient is greater than 2 years of age.
- OR**
- Patient has a documented adverse reaction or contraindication that precludes trial of 2 generic topical corticosteroids from preferred list.

Criteria for coverage of Protopic 0.1%:

- For areas other than groin or face, failed 2 generic topical corticosteroids in highest potency class and patient is greater than 18 years of age.
 - For groin and face failed 2 topical generic corticosteroids from preferred list in any potency class and patient is greater than 18 years of age.
- OR**
- Patient has a documented adverse reaction or contraindication that precludes trial of 2 generic topical corticosteroids from preferred list.

Criteria for coverage of Locoid:

- Has failed 2 topical generic corticosteroids from preferred list in medium potency class
- OR**
- Patient has a documented adverse reaction or contraindication that precludes trial of 2 generic topical corticosteroids from preferred list.

Procedures:

1. Exemption Forms will not be accepted for this drug class.
2. PAs can be submitted for patients who meet the above criteria by phoning ACS at 866-246-8505 or by faxing a PA request form (located at www.ncmedicaidpbm.com) to ACS at 866-246-8507. No PA request will be accepted prior to December 1, 2009.

Please select from the following options:

****Attention Pharmacists****

*Please discontinue originally prescribed medication listed above and change patient to the option selected below.
If the patient does not immediately need this prescription, please keep it on file for the next refill.*

Low Potency: <input type="checkbox"/> Hydrocortisone cream 2.5%	Medium Potency: <input type="checkbox"/> Betamethasone valerate 0.1% cream <input type="checkbox"/> Triamcinolone 0.025% ointment	High Potency: <input type="checkbox"/> Augmented betamethasone dipropionate 0.05% cream <input type="checkbox"/> Fluocinonide 0.05% cream or ointment	Very High Potency: <input type="checkbox"/> Augmented betamethasone dipropionate 0.05% ointment <input type="checkbox"/> Clobetasol propionate 0.05% cream or ointment
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Directions: _____

Dispense #: _____ Refill#: _____

Prescriber Signature: _____ Date: _____

Prescriber Name (please print): _____ DEA/NPI: _____

Note: By signing this document & checking the substitution above, you are consenting to this being a legal prescription & the pharmacy should fill it as such.