Prescriber Criteria Form

Eucrisa 2026 PA Fax 1566-A v1 010126.docx
Eucrisa (crisaborole)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Eucrisa (crisaborole).

Drug Name:
Eucrisa (crisaborole)

| | | |
|---|---|---|
| **Patient Name:** | | |
| **Patient ID:** | | |
| **Patient DOB:** | **Patient Phone:** | |
| **Prescriber Name:** | | |
| **Prescriber Address:** | | |
| **City:** | **State:** | **Zip:** |
| **Prescriber Phone:** | **Prescriber Fax:** | |
| **Diagnosis**: | **ICD Code(s):** | |

| **Please circle the appropriate answer for each question.** | | | |
|---|---|---|---|
| 1 | Is the requested drug being prescribed for a patient 3 months of age or older for mild to moderate atopic dermatitis?<br>[If no, then no further questions.] | Yes | No |
| 2 | Is the patient less than 2 years of age?<br>[If yes, then no further questions.] | Yes | No |
| 3 | Will the requested drug be used on sensitive skin areas (e.g., face, genitals, or skin folds)?<br>[If no, then skip to question 5.] | Yes | No |
| 4 | Has the patient experienced an inadequate treatment response, intolerance, or contraindication to a topical calcineurin inhibitor?<br>[No further questions.] | Yes | No |
| 5 | Is the requested drug being prescribed for use on non-sensitive (or remaining) skin areas?<br>[If no, then no further questions.] | Yes | No |
| 6 | Has the patient experienced an inadequate treatment response, intolerance, or contraindication to a medium or higher potency topical corticosteroid OR a topical calcineurin inhibitor? | Yes | No |

| | |
|---|---|
| Comments: | _____ |

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| By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan. |
| **Prescriber (or Authorized) Signature: _____ Date:_____** |