



Prior Authorization Form

Taclonex®

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: (check one) [] Taclonex® [] Other (specify) _____
Date: _____ Patient ID#: _____ DOB: _____
Patient Name: _____ Provider NPI: _____
Prescribing Physician: _____ Office Contact: _____
Office Fax #: _____ Office Phone: _____

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1. DIAGNOSIS FOR DRUG REQUESTED:

[] Psoriasis vulgaris
[] Other (specify) _____

2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

[] N/A If none or not applicable to diagnosis, indicate "N/A."

Table with 3 columns: Drug Name, Date, Duration. Includes horizontal lines for data entry.

3. PATIENT HISTORY:

a. Has the patient tried and failed or has an intolerance to concurrent use of calcipotriene (Dovonex®) and a topical betamethasone product? [] Yes [] No

Please add any other supporting medical information that may be useful in the decision-making process:

FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal use only Coverage effective date / /
Document # _____ Processor Initials _____ Date _____
M F Rx coverage Y N STANDARD - SELECT LOB _____
Previous Auth Y N Approved Reviewer Initials _____ Date _____