Trillium Health Resources
Pharmacy Prior Approval Request for

Topical Antihistamines

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
3. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Drug Name: _____ 2. Strength: _____ 3. Quantity Per 30 Days: _____
4. Length of Therapy (in Days): ☐ up to 10 Days

Clinical Information

Treatment for Atopic Dermatitis:

1. Has the member received previous treatment with at least one other topical antihistamine? ☐ **Yes** ☐ **No**
2. Has the member received previous treatment with at least two topical steroid creams? ☐ **Yes** ☐ **No**
3. Will the quantity be limited to 45 grams per 90 days? ☐ **Yes** ☐ **No**

For Atopic Dermatitis Reauthorization answer 1-5:

4. Have at least 3 months elapsed since the last time the member used the requested product? ☐ **Yes** ☐ **No**
5. **H**as the member benefited from therapy but remains at high risk? ☐ **Yes** ☐ **No**

** Please provide documentation that indicates the member has benefited from therapy but remains at high risk**

Treatment for Lichen Simplex Chronicus:

6. Has the member received previous treatment with at least two topical steroid creams? ☐ **Yes** ☐ **No**

For Lichen Simplex Chronicus Reauthorization answer 6-8:

7. Have at least 3 months elapsed since the last time the member used the requested product? ☐ **Yes** ☐ **No**
8. Has the member benefited from therapy but remains at high risk? ☐ **Yes** ☐ **No**

** Please provide documentation that indicates the member has benefited from therapy but remains at high risk**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277