

Anzupgo (delgocitinib)
Prior Authorization Request Form
Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION		
LAST NAME:		FIRST NAME:
PHONE NUMBER:		DATE OF BIRTH:
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
PATIENT INSURANCE ID NUMBER:		

☐ MALE ☐ FEMALE HEIGHT (IN/CM): _____ WEIGHT (LB/KG): _____ ALLERGIES: _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: [PRIMETHERAPEUTICS.COM/NOPP](https://www.primetherapeutics.com/nopp)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	FIRST NAME:
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:
NPI NUMBER:	DEA NUMBER:
PHONE NUMBER:	FAX NUMBER:
STREET ADDRESS:	
CITY:	STATE: ZIP CODE:
REQUESTER (if different than prescriber):	OFFICE CONTACT PERSON:

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
☐ NEW THERAPY ☐ RENEWAL IF RENEWAL: DATE THERAPY INITIATED:			
DURATION OF THERAPY (SPECIFIC DATES):			

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?

☐ **YES** (if yes, complete below) ☐ **NO**

MEDICATION/THERAPY
(SPECIFY DRUG NAME AND
DOSAGE):

DURATION OF THERAPY
(SPECIFY DATES):

**RESPONSE/REASON FOR
FAILURE/ALLERGY:**

2. LIST DIAGNOSES:

ICD-10:

☐ Chronic hand eczema(CHE)

☐ Other diagnosis: _____ ICD-10 Code(s):

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Is patient going to be using drug in combination with a clinical trial? ☐ Yes ☐ No

Does patient have a diagnosis of moderate to severe chronic hand eczema (CHE) with the eczema limited to the hands? ☐ Yes ☐ No Please submit documentation.

Has the chronic hand eczema persisted for more than 3 months? ☐ Yes ☐ No Please submit documentation.

Has the chronic hand eczema returned twice or more within the last 12 months even after being treated with at least 2 different topical therapies? ☐ Yes ☐ No Please submit documentation.

Is the prescriber a dermatologist or an allergist? ☐ Yes ☐ No

Has patient tried at least 2 different topical steroids? ☐ Yes ☐ No Please submit documentation.

Has the patient tried at least one topical steroid AND one topical calcineurin inhibitor? ☐ Yes ☐ No Please submit documentation.

Has the patient tried at least one topical steroid AND Eucrisa (crisaborole)? ☐ Yes ☐ No Please submit documentation.

Has the patient tried at least one topical steroid AND Zoryve (roflumist)? ☐ Yes ☐ No Please submit documentation.

Is patient taking another topical or oral JAK inhibitor at the same time? ☐ Yes ☐ No Please submit documentation.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909