Olux-E (clobetasol propionate foam)

Medical Necessity Prior Authorization Request Form

<table>
<thead>
<tr>
<th>Patient Information</th>
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<tr>
<td>Name:</td>
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<td>Member Phone #:</td>
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<td>Diagnosis:</td>
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<tr>
<th>Provider Information</th>
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<tr>
<td>Prescriber's Name:</td>
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<tr>
<td>Phone:</td>
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<tr>
<td>Office Address:</td>
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Complete and review information, sign and date. Fax signed form to Caremark’s Prior Authorization department at 888-836-0730. Caremark is an independent company that provides pharmacy benefit management services, including prior authorization review, on behalf of the member’s health plan. The Caremark fax machine is located in a secure location as required by HIPAA regulations.

Providers can call Caremark at 800-294-5979 with any questions concerning prior authorization procedures. Members should call Caremark Customer Care at 888-963-7290 with any questions. Members can also call their health plan at the number on their member ID cards.

**Formulary Alternatives: clobetasol propionate foam 0.05%**

Please circle the appropriate answer for each applicable question (Y for Yes, N for No).

1. Is the requested drug being prescribed for an FDA-approved indication? Y N
   [If the answer to this question is no, then no further questions are required.]

2. Has the participant demonstrated a failure of or intolerance to a majority (two or more in a class with at least two alternatives or one in a class with only one alternative) of the preferred formulary/preferred drug list alternatives for the given diagnosis (e.g. clobetasol propionate foam 0.05%)? Y N
   If yes, please submit documentation including medication(s) tried, dates of trial(s) and reason for treatment failure(s). ________________________________
   [If the answer to this question is yes, then skip to question 6.]

3. Does the participant have a documented contraindication to the listed formulary alternatives (e.g. clobetasol propionate foam 0.05%)? Y N
   If yes, please submit documentation including medication name(s) and
Olux-E (clobetasol propionate foam)

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contraindication._____________________________________________________________________________

[If the answer to this question is yes, then skip to question 6.]

4. Has the participant had an adverse reaction to or would be reasonably expected to have an adverse reaction to a majority (two or more in a class with at least two alternatives or one in a class with only one alternative) of the listed formulary agents used for the requested indication (e.g. clobetasol propionate foam 0.05%)? Y N

If yes, please submit documentation including medication name(s) and adverse reaction(s)._____________________________________________________________________________

[If the answer to this question is yes, then skip to question 6.]

5. Does the participant have a clinical condition for which there is no listed formulary agent to treat the condition based on published guidelines or clinical literature (e.g. clobetasol propionate foam 0.05%)? Y N

If yes, please submit documentation including the clinical condition._____________________________________________________________________________

6. Is the drug being prescribed within the manufacturer’s published dosing guidelines or does the dose fall within dosing guidelines found in accepted compendia or current literature (e.g. package insert, AHFS, Micromedex, current accepted guidelines, etc.)? Y N

Comments:_____________________________________________________________________________

I affirm that information on this form is accurate as of this date.

Prescriber’s Signature: Date: