



**Independence  
Blue Cross**

**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: \_\_\_\_\_

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

**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."

Drug Name	Date	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**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.**

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