

**Physician's Prior Authorization Questionnaire
Taclonex®**

Patient:

ID#:

DOB:

Patient Address:

Taclonex® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? *(Please do not use codes and be specific. **Psoriasis is not specific.**)*

2. Is the patient 18 years of age or older? Yes No

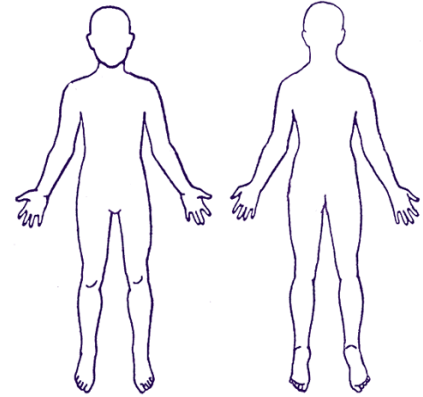
3. Does the patient have any known or suspected disorders of calcium metabolism? Yes No

If Yes, please list: _____

4. Does the patient have erythrodermic, exfoliative, or pustular psoriasis? Yes No

5. What percentage of body surface area will be covered? _____ %

Please circle the parts of the body that will be covered.



Front

Back

Note: There is a 420 gram per claim quantity limit on Taclonex®.

Treatment is limited to 4 weeks.

Physician's Signature

Date

Please **Print** Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx