

December 2, 2009

# Montana Healthcare Programs Notice

## Pharmacies, Physicians, Mid-Level Practitioners

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### Prior Authorization for Elidel<sup>®</sup> and Protopic<sup>®</sup>

Effective January 1, 2010, prior authorization for Elidel<sup>®</sup> and Protopic<sup>®</sup> will be required.

Elidel<sup>®</sup> (pimecrolimus) and Protopic<sup>®</sup> (tacrolimus) are prescription medications prescribed for the treatment of atopic dermatitis and eczema. The following criteria must be met to allow payment of Elidel<sup>®</sup> and Protopic<sup>®</sup>:

- Criteria
  - 2 years or older.
  - Patient must have recent trial and inadequate response to a prescription strength topical corticosteroid in the last 120 days.
- Limitations
  - Coverage will be limited to short-term therapy.
  - Maximum of one prescription will be authorized every 6 months.

The prescriber (physician, etc.) or pharmacy may submit requests by mail, telephone, or fax to:

Drug Prior Authorization Unit  
Mountain Pacific Quality Health Foundation  
3404 Cooney Drive  
Helena, MT 59602  
(406) 443-6002 or (800) 395-7961 (phone)  
(406) 443-7014 or (800) 294-1350 (fax)

Any questions regarding this notice can be directed to Wendy Blackwood at (406) 444-2738 or the Medicaid Drug Prior Authorization Unit at (406) 443-6002.

### Contact Information

For claims questions or additional information, contact Provider Relations:

**Provider Relations toll-free in- and out-of-state: 1-800-624-3958**

**Helena: (406) 442-1837**

**E-mail: [MTPRHelpdesk@ACS-inc.com](mailto:MTPRHelpdesk@ACS-inc.com)**

Visit the Provider Information website:

**<http://www.mtmedicaid.org>**