PRIOR AUTHORIZATION REQUEST
Isotretinoin

PATIENT:
Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber:
Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested: *Isotretinoin* **Qty Requested: _____**

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A Please answer the following questions

1. ❑ Yes ❑ No Has the patient tried and failed therapy with doxycycline, minocycline, or tetracycline for at least 30 days within the past 130 days?

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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If you have any questions, call: 800-753-2851