PRIOR AUTHORIZATION REQUEST
Topical Hyaluronic Acid Agents

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

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

Medication Requested:_____ 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. Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?
   - ☐ INITIAL - **please answer questions 3 - 5**
   - ☐ CONTINUATON - **please answer question 2**
2. ☐ Yes ☐ No Has the patient responded to the requested medication?
3. ☐ Yes ☐ No Is this medication being prescribed by a dermatologist?
4. What is the diagnosis or indication?
   - ☐ Burns
   - ☐ Radiation Dermatitis
   - ☐ Dermal Ulcers
   - ☐ Wounds
   - ☐ Xerosis
   - ☐ All other indications or diagnoses (Please specify):_____
5. ☐ Yes ☐ No Has the patient tried and failed treatment with ammonium lactate or a topical corticosteroid?

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

_____

_____

SECTION B Physician Signature

_____
PHYSICIAN SIGNATURE DATE

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

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FAX COMPLETED FORM TO: 877-251-5896

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