

Topical Tretinoin Prior Authorization Request Form
 DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

| Member Information <small>(required)</small> | | | Provider Information <small>(required)</small> | | |
|--|--------|------|--|--------|--------------|
| Member Name: | | | Provider Name: | | |
| Insurance ID#: | | | NP#: | | Specialty: |
| Date of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | Zip: | Office Street Address: | | |
| Phone: | | | City: | State: | Zip: |
| Medication Information <small>(required)</small> | | | | | |
| Medication Name: | | | Strength: | | Dosage Form: |
| <input type="checkbox"/> Check if requesting brand | | | Directions for Use: | | |
| <input type="checkbox"/> Check if request is for continuation of therapy | | | | | |
| Clinical Information <small>(required)</small> | | | | | |
| Select the diagnosis below: <input type="checkbox"/> Acne vulgaris <input type="checkbox"/> Actinic keratosis <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____ | | | | | |
| **Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.** *Previous therapies will be verified through pharmacy paid claims or submitted chart notes.* | | | | | |
| Prescriber Signature: _____ Date: _____ | | | | | |

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
 For urgent or expedited requests please call 1-800-711-4555.
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.