

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Isotretinoin Agents
Complete form in its entirety and fax to:
Prior Authorization of Benefits (PAB) Center at (866) 807- 6241

1. PATIENT INFORMATION

2. PHYSICIAN INFORMATION

Patient Name: _____	Prescribing Physician: _____
Patient ID #: _____	Physician Address: _____
Patient DOB: _____	Physician Phone #: _____
Date of Rx: _____	Physician Fax #: _____
Patient Phone #: _____	Physician Specialty: _____
Patient Email Address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician Email Address: _____

Manufacturer Risk Management Programs (S.M.A.R.T., S.P.I.R.I.T., I.M.P.A.R.T., A.L.E.R.T.)

- All prescriptions must have a Qualification Sticker filled out and
 - Initiation of therapy for female patients: require 2 negative pregnancy tests
 - Subsequent months: 1 negative pregnancy test monthly
- Prescribe no more than a 30-day supply
- Refills via phone, fax, or in an electronic format are NOT valid
- Patients must review and sign the information/Consent Form
- Prescriptions for female patients must be filled within 7 days

3. MEDICATION

4. STRENGTH

5. DIRECTIONS

6. QUANTITY PER 30 DAYS

<input type="checkbox"/> Accutane (isotretinoin) <input type="checkbox"/> Amnesteem (isotretinoin) <input type="checkbox"/> Claravis (isotretinoin) <input type="checkbox"/> Sotret (isotretinoin)	_____ _____	_____ _____	Specify: _____
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7. DIAGNOSIS: _____

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

For the treatment of acne:

- Yes No Has the patient been diagnosed with any of the following:
- Severe, persistent, and inflammatory nodular acne
 - Cystic acne
 - Acne vulgaris
 - Other, please specify _____

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Patient ID#: _____

For the treatment of acne (continued):

- Yes No Has the patient responded to conventional therapy?
- Yes No Has the patient tried and failed at least two conventional acne treatments, one of which is a one-month trial of systemic antibiotics?
- If yes, please indicate treatments tried and failed:**
 - Salicylic acid Sulfur preparations Clindamycin Benzoyl peroxide products
 - Tetracycline Erythromycin Differin (adapalene) Retin-A (tretinoin)
 - Minocycline Erythromycin Doxycycline Tazorac (tazarotene)
 - Trimethoprim/sulfamethoxazole Other: _____

For the Non- acne treatment:

- Yes No Has the patient been diagnosed with a keratinization disorder?
If yes, please specify below:
 - Lamellar ichthyosis Keratosis follicularis (Darier's disease)
 - Pityriasis rubra pilaris (PRP) Palmoplantar keratoderma (Keratosis palmaris et plantaris)
- Yes No Does the patient have the diagnosis of Folliculitis, gram-negative?
- Yes No Does the patient have the diagnosis of Severe rosacea?
- Yes No Does the patient have the diagnosis of Hidradenitis suppurativa?

9. PHYSICIAN SIGNATURE

Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.
 Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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