FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Retinoids (Topical) Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

- ❑ Acne vulgaris (i.e., acne)
- ❑ Actinic keratosis
- ❑ Hyperkeratosis
- ❑ Keloid Scar
- ❑ Wound healing (mild)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Select the medications the patient has a failure, contraindication, or intolerance to:

- ❑ Adapalene cream
- ❑ Adapalene gel
- ❑ Adapalene lotion
- ❑ Epiduo
- ❑ Epiduo Forte
- ❑ Onexton
- ❑ Tretinoin cream
- ❑ Tretinoin gel
- ❑ Tretinoin microsphere gel
- ❑ Other generic topical tretinoin product(s). Please specify: _____

Quantity limit requests:

What is the quantity requested per MONTH? _____

Does the patient require a greater quantity for the treatment of a larger surface area? ❑ **Yes** ❑ **No**

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.