



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

Retinoids (Topical) Prior Authorization Request Form
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Member Information (required) and Provider Information (required) form with fields for Member Name, Insurance ID#, Date of Birth, Street Address, City, State, Zip, Phone, Provider Name, NPI#, Specialty, Office Phone, Office Fax, Office Street Address, City, State, Zip.

Medication Information (required) form with fields for Medication Name, Strength, Dosage Form, and checkboxes for generic substitution and continuation of therapy.

Clinical Information (required) form with a section to select the diagnosis below, including options like Acne vulgaris, Actinic keratosis, Hyperkeratosis, Keloid Scar, Wound healing (mild), and Other diagnosis with ICD-10 Code(s).

Section to select the medications the patient has a failure, contraindication, or intolerance to, listing various retinoid products like Adapalene cream, Adapalene gel, Adapalene lotion, Epiduo, Epiduo Forte, Onexton, Tretinoin cream, Tretinoin gel, Tretinoin microsphere gel, and Other generic topical tretinoin product(s).

Quantity limit requests section asking for the quantity requested per MONTH and whether the patient requires a greater quantity for a larger surface area.

Section for 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.

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