hawk-i Healthy and Well Kids in Iowa | ia health link | Amerigroup An Anthem Company

FAX Completed Form To
1-844-512-9004

Provider Help Desk
1-800-454-3730
https://providers.amerigroup.com

Request for Prior Authorization
ISOTRETINOIN(ORAL)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization is required for oral isotretinoin therapy. Payment will be approved for preferred oral isotretinoin products for acne under the following conditions: 1. There are documented trials and therapy failures of systemic antibiotic therapy and topical tretinoin therapy. Documented trials and therapy failures of systemic antibiotic therapy and topical tretinoin therapy are not required for approval for treatment of acne conglobata. 2. Patients and providers must be registered in, and meet all requirements of, the iPLEDGE (www.ipledgeprogram.com) risk management program.
Payment for non-preferred oral isotretinoin products will be authorized only for cases in which there is documentation of trial(s) and therapy failure with a preferred agent(s). Initial authorization will be granted for up to 20 weeks. A minimum of two months without therapy is required to consider subsequent authorizations.

Preferred
☐ Amnestee ☐ Claravis ☐ Myriam ☐ Zenatane

Non-Preferred
☐ Absorica

Strength_____ **Dosage Instructions**_____**Quantity** ——**Days Supply**——

Diagnosis:_____Date of Initial Treatment: _____

*If PA extension, please specify exact date range of last drug-free interval: From:_____To:_____

Previous therapy (include drug name(s), strength and exact date ranges): _____

_____

Please **submit documentation of trial failures with systemic (not topical) antibiotic & vitamin A derivative** such as topical tretinoin or Differin (adapalene) include drug names, strength, exact date ranges and failure reasons:

_____

If female of child-bearing years, confirmed negative serum pregnancy test? Yes No

If yes, please list Prescriber:_____Date of pregnancy test:_____

Specify plan for contraception:_____

Reason for use of Non-Preferred drug requiring prior approval:_____

Other medical conditions to consider:_____

Possible drug interactions/conflicting drug therapies:_____

Attach lab results and other documentation as necessary.

PLEASE ALSO FAX THE iPLEDGE CONSENT FORM(s) SIGNED BY PATIENT.
THE iPLEDGE CONSENT FORM(s) CAN BE OBTAINED ONLINE AT www.ipledgeprogram.com.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.* ***CASE NUMBER:*** 1623305