Topical Acne Rosacea Products
Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-512-9004.
Provider Help Desk: 1-800-454-3730

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: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Prior authorization is required for topical acne agents (topical antibiotics and topical retinoids) and topical rosacea agents. Payment for topical acne and topical rosacea agents will be considered under the following conditions:

1. Documentation of diagnosis
2. For the treatment of acne vulgaris, benzoyl peroxide is required for use with a topical antibiotic or topical retinoid
3. Payment for nonpreferred topical acne products will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred topical acne agents of a different chemical entity from the requested topical class (topical antibiotic or topical retinoid)
4. Payment for nonpreferred topical rosacea products will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred topical rosacea agent
5. Requests for nonpreferred combination products may only be considered after documented trials and therapy failures with two preferred combination products
6. Requests for topical retinoid products for skin cancer, lamellar ichthyosis and Darier's disease diagnoses will receive approval with documentation of submitted diagnosis
7. Trial and therapy failure with a preferred topical antipsoriatic agent will not be required for the preferred tazarotene (Tazorac) product for a psoriasis diagnosis

8. Duplicate therapy with agents in the same topical class (topical antibiotic or topical retinoid) will not be considered

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Preferred

- ☐ Acanya
- ☐ Adapalene gel
- ☐ Azelex
- ☐ Metro cream
- ☐ Clindamycin
- ☐ Differin
- ☐ Epiduo
- ☐ Erythromycin
- ☐ MetroGel 1%
- ☐ MetroLotion
- ☐ Metronidazole (0.75% cream)
- ☐ Noritate
- ☐ Retin-A
- ☐ Tazorac

Nonpreferred

- ☐ Aczone
- ☐ Adapalene/benzoyl peroxide
- ☐ Adapalene cream/lotion/sol
- ☐ Aklief
- ☐ Altreno lotion
- ☐ Altralin
- ☐ Amzeeq
- ☐ Arazlo
- ☐ Azelaic acid gel 15%
- ☐ BenzaClin
- ☐ Benzamycin
- ☐ Benzamyci pak
- ☐ Cleocin T
- ☐ Clindamycin/BPO
- ☐ Clindamycin phosphate-tetinoin
- ☐ Duac
- ☐ Erythromycin/BPO
- ☐ Fabior
- ☐ Finacea
- ☐ Ivermectin cream
- ☐ Klaron
- ☐ Metronidazole gel and lotion
- ☐ Onexton
- ☐ Plixda pads
- ☐ Retin-A micro
- ☐ Sodium sulfa/sulf
- ☐ Soolanta
- ☐ Tretinoin
- ☐ Ziana
- ☐ Other (Specify):

If acne vulgaris, document concurrent benzoyl peroxide use:
Drug name and strength: _____
Dosing instructions: _____ Start date: _____

Nonpreferred topical acne or rosacea products
Acne diagnosis: Document trials with 2 preferred topical acne agents of a different chemical entity; if a nonpreferred combination product is requested, the 2 trials must be preferred topical acne combination products.

Rosacea diagnosis: Document trial with 1 preferred topical rosacea agent of a different chemical entity.
Preferred trial 1:
Name/dose: _____ Trial dates: _____
Failure reason: _____

Preferred trial 2:
Name/dose: _____ Trial dates: _____
Failure reason: _____
Medical or contraindication reason to override trial requirements: _____
_____
Other relevant information: _____
Possible drug interactions/conflicting drug therapies: _____

Attach lab results and other documentation as necessary.

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.