Medicaid
Children's Health Insurance Program

Request for Prior Authorization: Isotretinoin (Oral)

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Complete form in its entirety and fax to the Prior Authorization of Benefits Center at **844-512-9004**. If you have questions or need assistance, call the Provider Help Desk at **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 (PA) is required for oral isotretinoin therapy. Payment will be considered for preferred oral isotretinoin products for moderate to severe acne under the following conditions: 1. There are documented trials and therapy failures of systemic antibiotic therapy and topical vitamin A derivative (tretinoin or adapalene) therapy. Documented trials and therapy failures of systemic antibiotic therapy and topical vitamin A derivative therapy are not required for approval for treatment of acne conglobata; and 2. Prescriber attests patient has enrolled in and meets all requirements of the iPLEDGE 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 24 weeks. A minimum of eight weeks without therapy is required to consider subsequent authorizations.

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

Preferred
☐ Amnesteem ☐ Claravis ☐ Myorisan ☐ Zenatane

Non-Preferred
☐ Absorica

Date of initial treatment:_____
*If PA extension, please specify exact date range of last drug-free interval: From:_____ To:_____

Documentation of trial failures with systemic antibiotic & vitamin A derivative:

Systemic antibiotic drug trial: Drug name & dose:_____ Trial dates:_____

Failure reason:_____

Vitamin A derivative drug trial: Drug name & dose:_____ Trial dates:_____

Failure reason:_____

Is patient enrolled in iPLEDGE program and meets all program requirements? ☐ No ☐ Yes

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.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

***MUST MATCH PRESCRIBER LISTED ABOVE**

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.