Dermatologics: Acne Products – Isotretinoin

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and return by fax to **844-493-9207** as soon as possible to expedite this request. **Without this information, we may deny the request.**
Apple Health Preferred Drug list: **https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx**

Date of request:	Reference #:		MAS:
Patient	Date of birth		Amerigroup Washington, Inc. ID
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use		Qty/Days supply

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   a. If yes, has the patient been experiencing recurrent or persistent moderate to severe acne or rosacea? ☐ Yes ☐ No
   b. If yes, is there documentation showing a positive clinical response? ☐ Yes ☐ No

2. Indicate the patient's diagnosis:
   ☐ Moderate to severe acne
   ☐ Moderate to severe rosacea
   ☐ Other. Specify:

3. Are the provider and patient enrolled in the iPLEDGE Risk Evaluation and Mitigation Strategy (REMS) program?
   ☐ Yes ☐ No

4. For non-preferred isotretinoin products: Has the patient tried and failed at least two (2) preferred isotretinoin products?
   ☐ Yes, specify the isotretinoin products and duration:
   ☐ Preferred isotretinoin product is not tolerated. Specify:
   ☐ Other. Specify:

5. Indicate patient's current weight? ________ kg Date taken: ________

For diagnosis of moderate to severe acne

6. Has the patient tried and failed any of the following in combination with topical benzoyl peroxide or a topical retinoid (i.e. tretinoin) with a duration of use of at least 1 month? (Check all that apply)
   ☐ Oral antibiotics (i.e. doxycycline, erythromycin, trimethoprim-sulfamethoxazole)
   ☐ Benzoyl peroxide
   ☐ Topical retinoid (i.e. tretinoin)

☐ **For female patients**: Oral contraceptives (excludes progestin-only products)
☐ **For female patients**: Spironolactone
☐ Other. Specify:
☐ None of the above

7. Has the patient previously been treated with a full course of isotretinoin for acne?
   ☐ Yes ☐ No

   If yes, has it been at least 2 months since completion of the previous treatment?
   ☐ Yes ☐ No

For diagnosis of moderate to severe rosacea

8. Has the patient tried and failed any of the following in combination with oral antibiotics (i.e. doxycycline, clarithromycin, metronidazole) with a duration of use of at least 1 month? (Check all that apply)
   ☐ Topical ivermectin
   ☐ Topical antibiotics (i.e. metronidazole)
   ☐ Other. Specify:
   ☐ None of the above

REQUIRED WITH THIS REQUEST:

- Chart notes
- Labs
- Diagnostic tests results

Prescriber signature	Prescriber specialty	Date