PRO ACT
PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Isotretinoin Prior Authorization Request Form (Page 1 of 2)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Acne (e.g., severe recalcitrant nodular acne, severe acne, cystic acne)

❑ Other diagnosis:_____ ICD-10 Code(s): _____

Prescriber specialty:

Is the requested medication being prescribed by a dermatologist? ❑ **Yes** ❑ **No**

Select the medications the patient has a failure, contraindication, or intolerance to after an adequate trial (6 or more weeks):

❑ A topical retinoid or retinoid-like agent [e.g., Retin-A/Retin-A Micro (tretinoin)]

❑ Benzoyl peroxide and an oral antibiotic [e.g., Ery-Tab (erythromycin), Minocin (minocycline)]

❑ Benzoyl peroxide and a topical antibiotic [e.g., Cleocin-T (clindamycin), erythromycin, BenzaClin (benzoyl peroxide/clindamycin), Benzamycin (benzoyl peroxide/erythromycin)]

Reauthorization:

If this is a reauthorization request, answer the following questions:

After greater than 2 months **OFF** therapy, is persistent or recurring severe recalcitrant nodular acne still present? ❑ **Yes** ❑ **No**

What is the patient's weight? _____

What is the patient's total cumulative dose (mg/kg) for the total duration oftherapy? _____

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Are there any 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.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	