

Prior Authorization Request Form for Retinoid (topical)

Member Information

Patient Name _____
 Cardholder ID _____
 Date of Birth _____
 Address _____
 City, State Zip _____
 Phone Number _____

Provider Information

Provider Name _____
 DEA Number _____
 Address _____
 City, State and Zip _____
 Phone Number _____
 FAX Number _____

Pharmacy Information

Pharmacy Name _____ Address _____ Phone _____

Criteria for Approval:

1. Acne agent requested: *Check one (please include strength):*
 - Avita (tretinoin) _____
 - Retin-A (tretinoin) _____
 - Retin-A Micro (tretinoin gel, microsphere) _____
 - Differin (tretinoin) _____
2. Is the patient 12 years of age or older? Yes No
3. Has the patient been on Retinoid therapy for the previous six months? Yes No
4. Diagnosis of Acne Vulgaris or Acne Rosacea? Yes No
5. Diagnosis of Actinic Keratosis? Yes No
6. Has the patient tried and failed at least two of the following anti-acne products? Yes No
 - Glycolic Acid products
 - Resorcinol products
 - Benzoyl Peroxide products (i.e., Oxy-10, Benzac AC, Triaz)
 - Decarboxylic acids (i.e., Azelex)
 - Topical antibiotics (i.e., clindamycin, erythromycin, sulfacetamide)
 - Oral antibiotics (i.e., tetracycline, erythromycin, doxycycline)
 - Sulfur products
 - Salicylic Acid products (i.e., Cleari, Stri-Dex)

Provider Signature _____ Date _____

Fax completed forms to (866) 284-4509.

For Office Use Only

Date/Time Received _____
 Reference Number _____
 Approved / Denied (Circle One) by _____ Date _____
 Date/Time Returned to Provider _____

If you have any questions regarding this form, contact the Prior Authorization Department Toll Free at (866) 284-4492 or FAX Toll Free at (866) 284-4509.

FOX Rx Care Utilization Management
 3375-I Capital Circle NE
 Tallahassee, FL 32308

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