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
   - ☐ Sulfur products
   - ☐ Resorcinol products
   - ☐ Salicylic Acid products (i.e., Cleari, Stri-Dex)
   - ☐ 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)

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
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