



Request for Prior Authorization
ISOTRETINOIN (ORAL)

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization is required for oral isotretinoin therapy. Payment will be approved for preferred oral isotretinoin products for acne under the following conditions: 1. There are documented trials and therapy failures of systemic antibiotic therapy and topical tretinoin therapy. Documented trials and therapy failures of systemic antibiotic therapy and topical tretinoin therapy are not required for approval for treatment of acne conglobata. 2. Patients and providers must be registered in, and meet all requirements of, the iPLEDGE (www.ipledgeprogram.com) risk management 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 20 weeks. A minimum of two months without therapy is required to consider subsequent authorizations.

Preferred

Non-Preferred

- Amnesteem, Claravis, Myorisan, Zenatane, Absorica. Includes Strength, Dosage Instructions, Quantity, Days Supply.

Diagnosis: Date of Initial Treatment:

\*If PA extension, please specify exact date range of last drug-free interval: From: To:

Previous therapy (include drug name(s), strength and exact date ranges):

Please submit documentation of trial failures with systemic (not topical) antibiotic & vitamin A derivative such as topical tretinoin or Differin (adapalene) include drug names, strength, exact date ranges and failure reasons:

If female of child-bearing years, confirmed negative serum pregnancy test? Yes No. If yes, please list Prescriber: Date of pregnancy test:

Specify plan for contraception:

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.

PLEASE ALSO FAX THE iPLEDGE CONSENT FORM(S) SIGNED BY PATIENT. THE iPLEDGE CONSENT FORM(S) CAN BE OBTAINED ONLINE AT www.ipledgeprogram.com.

Prescriber signature (Must match prescriber listed above.) Date of submission

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.