



**Request for Prior Authorization  
TOPICAL ACNE AND ROSACEA PRODUCTS**

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID # 	Patient name	DOB
Patient address		
Provider NPI 	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
<b>Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.</b>		
Pharmacy NPI 	Pharmacy fax	NDC 

Prior authorization (PA) is not required for preferred topical acne agents (topical antibiotics and topical retinoids) for members under 21 years of age. PA is required for preferred topical acne agents for members 21 years or older, non-preferred topical acne agents and all topical rosacea agents. Payment will be considered under the following conditions:

- 1) Documentation of diagnosis; and
- 2) For the treatment of acne vulgaris, benzoyl peroxide is required for use with a topical antibiotic or topical retinoid; and
- 3) Payment for non-preferred topical acne products will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred topical acne agents of a different chemical entity from the requested topical class (topical antibiotic or topical retinoid); and
- 4) Payment for non-preferred topical rosacea products will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred topical rosacea agent; and
- 5) Requests for non-preferred combination products may only be considered after documented trials and therapy failures with two preferred combination products; and
- 6) Requests for topical retinoid products for skin cancer, lamellar ichthyosis, and Darier’s disease diagnoses will receive approval with documentation of submitted diagnosis; and
- 7) Duplicate therapy with agents in the same topical class (topical antibiotic or topical retinoid) will not be considered.

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Preferred	Non-Preferred		
Adapalene Gel	Acanya	BenzaClin	MetroCream
Avita Gel	Aczone	Benzamycin	Metronidazole Gel & Lotion
Azelex	Adapalene/Benzoyl Peroxide	Benzamycin Pak	Noritate
Clindamycin	Adapalene Cream/Lotion/Sol	Cleocin T	Onexton
Clindamycin/BPO	Aklief	Clindamycin Phosphate-Tretinoin	Plixda Pads
Differin	Altreno Lotion	Duac	Retin-A Micro
Epiduo	Amzeeq	Erythromycin/BPO	Sodium Sulfa/Sulf
Erythromycin	Arazlo	Fabior	Soolantra
MetroGel 1%	Atralin	Finacea	Tretinoin
MetroLotion	Avita Cream	Ivermectin cream	Ziana
Metronidazole 0.75% Cream	Azelaic Acid Gel 15%	Klaron	Zilxi
Retin-A	Other (specify)		
Tazarotene Cream			
Tazorac			



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Strength

Dosage Form

Dosage Instructions

Quantity

Days Supply

Diagnosis:

If acne vulgaris, document concurrent benzoyl peroxide use:

Drug Name & Strength:

Dosing Instructions: Start date:

Non-Preferred Topical Acne or Rosacea Products

Acne Diagnosis: Document trials with two preferred topical acne agents of a different chemical entity; if a non-preferred combination product is requested, the two trials must be preferred topical acne combination products

Rosacea diagnosis: Document trial with one preferred topical rosacea agent of a different chemical entity:

Preferred Trial 1: Name/Dose: Trial Dates:

Failure reason:

Preferred Trial 2: Name/Dose: Trial Dates:

Failure reason:

Medical or contraindication reason to override trial requirements:

Other relevant information:

Possible drug interactions/conflicting drug therapies:

Attach lab results and other documentation as necessary.

Table with 2 columns: Prescriber signature (Must match prescriber listed above.) and 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.