

PRIOR AUTHORIZATION REQUEST FORM ACNE VULGARIS AND ROSACEA

For authorization, please answer each question and fax this form PLUS chart notes back to Real Rx at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance 385-425-5094.

Product being requested: _____

Dosing/Frequency:_____

if you have prior authorization questions, please can for assistance 383-423-3034.								
Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.								
Date:	Member Name:	ID#:						
DOB:	Gender:	Physician:						
Office Phone:	Office Fax:	Office Contact:						
Height/Weight:								
Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.								
Please note the following do not require prior authorization: adapalene, azelaic acid, topical antibiotics, topical benzoyl peroxide, topical metronidazole, topical retinoids								

if the request is for reauthorization, proceed to reauthorization section					
Qu	estions	Yes	No	Comments/Notes	
1. Is this request for an expedited review?					
By checking the "Yes" box to request an expedited review (24					
hours), you are certifying that applying the standard review					
time frame (72 hours) may place the member's life, health, or					
i	ability to regain maximum function in serious jeopardy.				
Acne Vulgaris					
1.	Does the member have a diagnosis of acne vulgaris?			Please provide documentation	
2.	Does documentation show that the member has tried and			Please provide documentation	
	failed ALL of the following categories:				
	 topical benzoyl peroxide 				
	 topical or oral antibiotic (e.g. clindamycin, sulfacetamide, erythromycin) 				
	 topical retinoid (e.g. adapalene, tretinoin, tazarotene) 				
	 Topical generic dapsone or tazarotene 				
Rosacea					
1.	Does the member have a diagnosis of rosacea?			Please provide documentation	
2.	Does documentation show that the member has failed a trial			Please provide documentation	
	of a topical metronidazole agent, a topical generic azelaic acid				
	and ivermectin cream?				
REAUTHORIZATION					
1	Is the request for regulthorization of therapy?				

2. Has the member's therapy been re-evaluated within the past 12 months?							
Does the member show a continued medical need for the therapy?			Please provide documentation				
What medications and/or treatment modalities have been tried in the past for this condition? Please document							
name of treatment, reason for failure, treatment dates, etc.							
Additional information:							
Physician's Signature:							
Additional information: Physician's Signature:							

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Policy: PHARM- 001

Origination Date: 10/02/2018 Reviewed/Revised Date: 05/22/2024 Next Review Date: 05/24/2025 Current Effective Date: 06/01/2024

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