HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

ACNE VULGARIS AND ROSACEA

Aczone®, Aklief®, Epiduo® Forte, Fabior®, Mirvaso®, Rhofade®, Soolantra®, Tazorac®

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department 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

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

Product being requested: ☐ Aczone® (dapsone), ☐ Aklief® (trifarotene), ☐ Epiduo® Forte (adapalene/benzoyl peroxide), ☐ Fabior® (tazarotene), ☐ Mirvaso® (brimonidine), ☐ Rhofade® (oxymetazoline), ☐ Soolantra® (ivermectin), ☐ Tazorac® (tazarotene)

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
ACZONE® or AKLIEF® or EPIDUO® FORTE or FABIOR® or TAZORAC®			
1. Does the member have a diagnosis of acne vulgaris?	☐	☐	**Please provide documentation**
2. Does documentation show that the member has tried and 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	☐	☐	**Please provide documentation**
MIRVASO® or RHOFADE® or SOOLANTA®			
1. Does the member have a diagnosis of rosacea?	☐	☐	**Please provide documentation**
2. Does documentation show that the member has failed a trial of a topical metronidazole agent?	☐	☐	**Please provide documentation**
3. Does documentation show that the member has failed a trial of a topical generic azelaic acid?	☐	☐	**Please provide documentation**

4. Soolantra®is the preferred product. If Rhofade® or Mirvaso® is being requested, has Soolantra®been trialed and failed first?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 12 months?	☐	☐	
3. 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:

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

Policy: PHARM-CHIP-001
Origination Date: 07/01/2024
Reviewed/Revised Date: 05/27/2025
Next Review Date: 05/27/2026
Current Effective Date: 06/01/2025