HEALTHY U MEDICAID

PRIOR AUTHORIZATION REQUEST FORM
ACNE VULGARIS AND ROSACEA

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U 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: _____
Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Question	Yes	No	Comments/Notes
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 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**
ROSACEA			
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, a topical generic azelaic acid and ivermectin cream?	☐	☐	**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:

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Policy: PHARM-HU-001
Origination Date: 01/01/2022
Reviewed/Revised Date: 05/22/2024
Next Review Date: 05/22/2025
Current Effective Date: 06/01/2024