

Prior Authorization Form

Isotretinoin Products

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Isotretinoin Products.

Drug Name
(specify drug) _____

Quantity _____ Frequency _____ Strength _____
Route of Administration _____ Expected Length of Therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Comments: _____

Please circle the appropriate answer for each question.

1. Does the patient have any of the following diagnoses: A) severe recalcitrant nodular acne vulgaris, B) refractory acne vulgaris, C) severe refractory rosacea? Y N

[If no, then skip to question 4.]

2. Has the patient tried and had an inadequate treatment response to any topical acne product AND an oral antibiotic? Y N

[Note: topical products include salicylic acid, benzoyl peroxide, azelaic acid, adapalene, tretinoin, tazarotene, clindamycin, erythromycin, or metronidazole for rosacea] \ [Note: oral antibiotics include minocycline, doxycycline, tetracycline, erythromycin, trimethoprim-sulfamethoxazole, trimethoprim, azithromycin]

3. Will treatment be limited to 40 weeks (2 courses) or less AND with at least 8 weeks between each course?

Y N

[No further questions.]

4. Does the patient have any of the following diagnoses: A) neuroblastoma, B) cutaneous T-cell lymphoma (CTCL) (e.g., mycosis fungoides, Sezary syndrome), C) is at high risk for developing skin cancer (squamous cell cancers), D) transient acantholytic dermatosis (Grover's Disease), E) keratosis follicularis (Darier Disease), F) lamellar ichthyosis, G) pityriasis rubra pilaris?

Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date