

Please note: All information below is required to process this request.

Fax to 1-844-403-1029 Mon-Sat: 7am to 7pm Central

Topical Acne Agents Prior Authorization Request Form

Member Information (required)				Provider Information (required)		
Member Nam	e:		Provider Name:			
Insurance ID#:			NPI#:		Specialty:	
Date of Birth:			Office Phone:			
Street Address:			Office Fax:			
City:	State:	Zip:	Office Street Ad	Office Street Address:		
Phone:			City:	State:	Zip:	
		Medication	Information (re	equired)		
Medication Name:			Strength:		Dosage Form:	
☐ Check if requesting brand			Directions for Use:			
☐ Check if re	quest is for continuatio	n of therapy				
		Clinical I	nformation (requ	ired)		
Select the d	liagnosis below:					
□ Acne vul	garis					
☐ Plaque p	soriasis [Tazorac (ta:	zarotene) only]				
☐ Other diagnosis:			ICD-10 Code(s):			
Medication	history:					
		ure of a generic topica ım/sulfur, sulfacetamic			oin, clindamycin phosphate,	
erythromych	1, Sullacetamide Soul	im/sullur, sullacetamic	ie sodium) in the last	120 days? u re s	S U NO	
Are there any ot this review?	ther comments, diagnose	es, symptoms, medications	s tried or failed, and/or ar	ny other information	the physician feels is important to	
Please note:		enied unless all required info I requests please call 1-855				
		for non-urgent requests and				

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