

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

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

## Extina, Xolgel<sup>™</sup> & Xolegel<sup>™</sup> Duo Prior Authorization Request Form

		OR FUTURE USE. FORMS					
Member Information (required)			Provider Information (required)				
Member Name:			Provider Name:				
Insurance ID#:			NPI#:	NPI#:		Specialty:	
Date of Birth:			Office Phone:				
Street Address:			Office Fax:				
City:	State:	Zip:	Office Street Ad	Office Street Address:			
Phone:	I	I	City:	State:		Zip:	
		Medication	Information (re	equired)			
Medication Name:			Strength:	oquii ou j	Dosage Form:		
☐ Check if requesting <b>brand</b>			Directions for U	Directions for Use:			
	uest is for <b>continuatior</b>	of therapy					
		Clinical I	nformation (requ	ired)			
Select the c	liagnosis below:						
☐ Seborrhe	eic dermatitis in imm	nunocompetent patie	nts				
Other dia	ignosis:	ICD-10 Cod	e(s):				
Clinical info	ormation:						
	ent had a trial and f <b>⊒ Yes  □ No</b>	ailure (a minimum of	60 day trial) of keto	oconazole crea	am or sham	poo in the past	
	nit requests:	per MONTH?					
		ding the plan limitat					
		antity to cover a large					
☐ Other:							
Are there any of this review?	ther comments, diagnose	es, symptoms, medications	s tried or failed, and/or ar	ny other informatio	on the physicia	an feels is important to	
Please note:	For urgent or expedited	enied unless all required info d requests please call 1-855 l for non-urgent requests and	-401-4262.				

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