Prior Authorization Request Form for
trifarotene 0.005% cream **(Aklief)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. This agent has been identified as having cost-effective alternatives including adapalene (cream, gel, and lotion), clindamycin (cream, gel, lotion, and solution), clindamycin/benzoyl peroxide (combination) gel, and tretinoin (cream, and gel). These agents are available without a PA. Please consider changing the prescription to one of these agents.	Proceed to question **2**
2. What is the indication or diagnosis?	☐ Acne Vulgaris – Proceed to question **3** ☐ Other – **STOP Coverage not approved**
3. Please explain why this agent is required and the patient cannot take the formulary alternatives. **Sign and date below**	

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[13 May 2020]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: