Prior Authorization Request Form for
Topical Acne and Rosacea Agents: Topical Retinoids and Combinations

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. Does the patient have a diagnosis of acne vulgaris?	☐ Yes Proceed to question 2	☐ No **STOP** **Coverage not approved**
2. Has the patient tried and failed at least three preferred topical generic acne products, including at least two different strengths of tretinoin? The preferred medications are adapalene (cream, gel, lotion), clindamycin (cream, gel, lotion, solution), clindamycin/benzoyl peroxide (combination) gel, tretinoin (cream, gel), and sulfacetamide sodium/sulfur lotion.	☐ Yes Sign and date below	☐ No Proceed to question 3
3. Has the patient experienced an adverse reaction or inadequate response to formulary preferred topical tretinoin agents that is not expected to occur with the non-preferred product?	☐ Yes Sign and date below	☐ No Proceed to question 4
4. Is the requested medication Epiduo or Epiduo Forte (generic adapalene/benzoyl peroxide)?	☐ Yes Proceed to question 6	☐ No Proceed to question 5
5. Is the requested medication Veltin or Ziana (generic tretinoin 0.025%/clindamycin 1.2%)?	☐ Yes Proceed to question 7	☐ No **STOP** **Coverage not approved**
6. Does the patient require combination topical adapalene/benzoyl peroxide?	☐ Yes Sign and date below	☐ No **STOP** **Coverage not approved**
7. Does the patient require this particular strength of combination topical tretinoin 0.025%/clindamycin 1.2%?	☐ Yes Sign and date below	☐ No **STOP** **Coverage not approved**

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

_____ _____
Prescriber Signature Date

[06 September 2018]

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