Prior Authorization Request Form for

Topical Acne and Rosacea Agents: Topical Azelaic Acid Products

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

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. What medication is being requested?	☐ Azelex Proceed to question 2	☐ Finacea Proceed to question 5
2. Does the patient have a diagnosis of acne?	☐ Yes Proceed to question 3	☐ No **STOP** **Coverage not approved**
3. Is the patient pregnant?	☐ Yes Sign and date below	☐ No Proceed to question 4
4. Has the patient tried and failed at least three topical acne agents, including combination therapy with clindamycin and benzoyl peroxide?	☐ Yes Sign and date below	☐ No **STOP** **Coverage not approved**
5. Does the patient have a diagnosis of rosacea?	☐ Yes Proceed to question 6	☐ No **STOP** **Coverage not approved**
6. Is the patient pregnant?	☐ Yes Sign and date below	☐ No Proceed to question 7
7. Has the patient tried and failed or cannot tolerate topical metronidazole? Topical generic products are metronidazole 1% gel, 0.75% lotion, and 0.75% cream.	☐ 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

[3 August 2018]

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