Prior Authorization Request Form for
Topical Acne and Rosacea Agents: Topical Dapsone Products

JOHNS HOPKINS MEDICINE
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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. Does the patient have a diagnosis of acne vulgaris?	☐ Yes Proceed to question 2	☐ No **STOP** **Coverage not approved**
2. Is the patient greater than or equal to 13 years of age?	☐ Yes Proceed to question 3	☐ No **STOP** **Coverage not approved**
3. Does the patient have a diagnosis of inflammatory acne?	☐ Yes Proceed to question 4	☐ No **STOP** **Coverage not approved**
4. Has the patient tried and failed at least three preferred topical generic acne products, including combination therapy with clindamycin and benzoyl peroxide products? The formulary 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 **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

[01 November 2017]

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