Prior Authorization Request Form for
clascoterone **(Winlevi)**

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. Adapalene (cream, gel, lotion), clindamycin (cream, gel, lotion, solution), clindamycin/benzoyl peroxide (combination) gel, tretinoin (cream, gel), and spironolactone (tablets) are available to DoD beneficiaries without requiring prior authorization. Please consider changing the prescription to a formulary preferred medication.	☐ Acknowledged Proceed to question **2**	
2. Does the patient have a diagnosis of acne vulgaris? **Note: Non-FDA-approved uses are not approved, including for hair loss**	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Is the patient 12 years of age or older?	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. Is the requested medication prescribed by or in consultation with a dermatologist?	☐ Yes Proceed to question **5**	☐ No **STOP** Coverage not approved
5. Does provider acknowledge a potential increased risk of hypothalamic-pituitary-adrenal axis suppression in adolescents compared to adults?	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved
6. Has the patient tried and failed or has contraindications to a topical retinoid product and to a combination of topical clindamycin and benzoyl peroxide product?	☐ Yes Proceed to question **7**	☐ No **STOP** Coverage not approved
7. Has the patient tried and failed or has contraindications to at least one oral medication (such as, spironolactone, a combined oral contraceptive, OR isotretinoin) for acne?	☐ Yes Proceed to question **8**	☐ No **STOP** Coverage not approved

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8. Please provide the date of when the patient previously tried each medication or the contraindication for each medication listed below.

Note: The dates for each medication or contraindication to each medication listed below must be provided or your case could be denied.

Category	Drug	Drug response	
		Date of trial and failure	Contraindication to medication
Topical retinoid			
Combination topical clindamycin with benzoyl peroxide			
Oral medication (such as, spironolactone, a combined oral contraceptive, OR isotretinoin)			

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 _____

[02 March 2022]

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