

**Differin® (adapalene) Prior Authorization Request Form (Page 1 of 2)**

<b>Member Information (required)</b>			<b>Provider Information (required)</b>		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
<b>Medication Information (required)</b>					
Medication Name:			Strength:	Dosage Form:	
<input type="checkbox"/> Check if requesting <b>brand</b>			Directions for Use:		
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>					
<b>Clinical Information (required)</b>					
<b>Select the diagnosis below:</b>					
<input type="checkbox"/> Acne vulgaris					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
<b>Select the medications the patient has a failure, contraindication, or intolerance to:</b>					
<input type="checkbox"/> Acanya					
<input type="checkbox"/> Adapalene cream					
<input type="checkbox"/> Adapalene gel					
<input type="checkbox"/> Benzamycin					
<input type="checkbox"/> Clindamycin-benzoyl peroxide					
<input type="checkbox"/> Differin cream					
<input type="checkbox"/> Differin gel					
<input type="checkbox"/> Differin lotion					
<input type="checkbox"/> Epiduo					
<input type="checkbox"/> Epiduo Forte					
<input type="checkbox"/> Erythromycin-benzoyl peroxide					
<input type="checkbox"/> Fabior					
<input type="checkbox"/> Neuac					
<input type="checkbox"/> Onexton					



1230 US Highway 11  
Gouverneur, NY 13642  
Phone: 1-877-635-9545

Prior Authorization Fax: 1-844-712-8129

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.  
**Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.**  
**Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.**

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): \_\_\_\_\_ Date: \_\_\_\_\_

### PROACT INTERNAL USE ONLY:

#### Clinical Review Decision

Approved, through

Denied (documentation attached, if necessary)

#### Tracking:

1 <sup>st</sup> Attempt		2 <sup>nd</sup> Attempt		Letter Mailed:	
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