

**Finacea® 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"/> Rosacea					
<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"/> Metronidazole cream					
<input type="checkbox"/> Metronidazole gel					
<input type="checkbox"/> Metronidazole lotion					

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

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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.**



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

Prior Authorization Fax: 1-844-712-8129

## Finacea® Prior Authorization Request Form (Page 2 of 2)

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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This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of ProAct. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Finacea\_Jan\_2018