PRO ACT
PHARMACY BENEFIT MANAGEMENT

1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Retinoids (Topical) Prior Authorization Request Form (Page 1 of 2)

Member Information (required)			Provider Information (required)		
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:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand** ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Acne vulgaris
❑ Actinic keratosis
❑ Alopecia areata
❑ Hyperkeratosis
❑ Keloid Scar
❑ Systematized epidermal nevus
❑ Wound healing (mild)
❑ Other diagnosis:_____________________________ICD-10 Code(s): ____________________________________

Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Atralin gel
❑ Avita cream
❑ Avita gel
❑ Epiduo
❑ Epiduo Forte
❑ Onexton
❑ Retin-A cream
❑ Retin-A gel
❑ Retin-A micro
❑ Tretinoin cream
❑ Tretinoin gel
❑ Tretinoin microsphere gel
❑ Other retinoid product(s). Please specify: ____

Quantity limit requests:

What is the quantity requested per MONTH? _________

Does the patient require a greater quantity for the treatment of a larger surface area? ❑ **Yes** ❑ **No**

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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:					
1st Attempt		2nd Attempt		Letter Mailed:	

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