

# ATRALIN (tretinoin) STEP THERAPY

## PRIOR AUTHORIZATION REQUEST FORM

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

Complete and review information, sign and date. Fax signed form to Caremark's prior authorization department at 1-888-836-0730. The Caremark fax machine is located in a secure location as required by HIPAA regulations. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

Providers may call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures. Members should call Caremark Customer Care at 1-888-963-7290 with any questions. Members may also call their health plan at the number indicated on their Member ID cards.

**Please circle the appropriate answer for each applicable question (Y for Yes, N for No).**

1. Does the participant have the diagnosis of Keratosis Follicularis (Darier's disease, Darier-White disease)? Y      N  
[If the answer to this question is yes, no further questions are required.]
2. Does the participant have the diagnosis of Acne Vulgaris? Y      N
3. Has the participant tried and failed products from the following categories: Y      N  
Salicylic Acid products (e.g., Clearasil, Stri-Dex)  
Benzoyl Peroxide products (e.g., Oxy-10, Benzac AC, Triaz)?  
[If the answer to this question is yes, no further questions are required.]
4. Has the physician considered using the therapies listed in question 3, but deemed all of them inappropriate for the patient? Y      N

**Comments:**

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*I affirm that the information given on this form is accurate as of this date.*

**Prescriber (or Authorized) Signature and Date:**