

SOTRET (isotretinoin)

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 patient have a diagnosis of acne (e.g., severe [recalcitrant] nodulocystic acne, treatment-resistant acne or acne producing physical or psychological scarring, or cystic acne? Y N
[If the answer to this question is yes, skip to question 7.]
2. Does the patient have a diagnosis of carcinoma, e.g., basal cell carcinoma, squamous cell carcinoma? Y N
[If the answer to this question is yes, skip to question 9.]
3. Does the patient have a diagnosis of malignant neoplasm, e.g., cutaneous T-cell lymphoma, neuroblastoma? Y N
[If the answer to this question is yes, skip to question 9.]
4. Does the patient have a diagnosis of psoriasis? Y N
[If the answer to this question is yes, skip to question 9.]
5. Does the patient have a diagnosis of severe refractory Rosacea? Y N
[If the answer to this question is yes, skip to question 9.]

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6. Does the patient have a diagnosis of severe Keratinization Disorders, e.g., keratosis follicularis (Darier-White disease), pityriasis rubra pilaris, lamellar ichthyosis, ketatosis palmaris et plantars, congenital ichthyosiform erythroderma, lichen planus? Y N
- [If the answer to this question is yes, skip to question 9.]
7. Has the patient tried and had insufficient response to systemic antibiotics? Y N
8. Has the patient tried and failed any of the following treatments in addition to systemic antibiotics? Y N
- Topical antibiotics (e.g., topical clindamycin or topical erythromycin)
 - Benzoyl peroxide products (e.g., Oxy-10, Benzac)
 - Topical retinoids (e.g., Retin-A, Avita)
 - Birth control pills that are approved for acne treatment (females only)
9. Is patient currently taking a tetracycline class product? Y N
- [If the answer to this question is no, skip to question 11.]
10. Will the tetracycline class product be discontinued prior to isotretinoin therapy? Y N
11. Has the patient taken a previous course (up to 20 weeks) or oral isotretinoin therapy? Y N
- [If the answer to this question is no, no further questions needed.]
12. Has the patient been off therapy for at least 8 weeks? Y N
13. Has the patient received 2 courses (up to a total of 40 weeks) of oral isotretinoin therapy? Y N

Comments:

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

Prescriber (or Authorized) Signature and Date: