PriorityHealth

Pharmacy
Prior Authorization Form

Last Reviewed: Nov. 09

For Prior Authorization please fax to: (877)974-4411 toll free, or (616)942-8206

This form applies to: ☐ **Commercial Plan** ☒ **Medicaid Plan** ☐ **Medicare Plan**

Sotret and Amnesteem (isotretinoin)

☐ Urgent ☐ Non-urgent

Member Name:	Member #:
DOB:	Gender:
Provider Name:	Provider Phone:
Provider Office Address:	
Provider Office Contact Name:	Provider Fax:
Provider Signature:	Provider NPI:
Date:	Member's PCP:

Product:

☐ Sotret capsules	☐ 10 mg	☐ 20 mg	☐ 30 mg	☐ 40 mg
☐ Amnesteem capsules	☐ 10 mg	☐ 20 mg		☐ 40 mg

Dose: ____ Start date: ______________________

Priority Health Precertification Requirements:

Authorization of Sotret and Amnesteem requires:

- Patient must be registered with iPledge

Please Complete the Following Information:

Patient is registed with iPledge:

☐ Yes

☐ No – Rationale for use: ____

*** All fields must be complete and legible for Prior Authorization Review***

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YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX