

# Pharmacy Prior Authorization Form

Last Reviewed: Nov. 11

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 registered 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**