PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Commercial (Traditional)** ☐ **Commercial (Individual/Optimized)**
☒ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Acitretin (brand name Soriatane®)

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New Request ☐ Continuation Request

Drug product:
☐ Acitretin 10 mg capsule
☐ Acitretin 17.5 mg capsule
☐ Acitretin 25 mg capsule

Start date (or date of next dose): _____
Dose Requested: _____
Dosing frequency: _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Diagnosis of moderate to severe psoriasis
2. At least a 90 day trial of methotrexate AND 90 day trial of high dose topical steroid (example: augmented betamethasone, clobetasol).

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

☐ Moderate to severe psoriasis
☐ *Other – the patient's condition is:* _____
Rationale for use: _____

B. What other treatments has the patient tried?

☐ Methotrexate, Dates of use:_____
☐ Betamethasone dipropionate, Dates of use:_____
☐ Clobetasol, Dates of use:_____
☐ Halobetasol, Dates of use:_____
☐ Other, Dates of use:_____

Additional information

Note:: Acitretin is covered with a max quantity of 2 capsules per day.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 01/2017
Last reviewed 01/2019