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.

Oral Isotretinoin (Claravis®, Amnesteem®, Myorisan®, Zenatane™)

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:
- ☐ Claravis
- ☐ Amnesteem
- ☐ Myorisan
- ☐ Zenatane

Start date (or date of next dose): ______________________

Date of last dose (if applicable): ______________________

Dose:__________ **Dose Frequency**:______________________

Precertification Requirements

Initial Criteria

ALL of the following must be met:

1. Treatment of severe, recalcitrant nodular acne unresponsive to conventional therapy.
2. Trial and failure of 1 systemic antibiotic in combination with 1 generic topical retinoid used consistently for a total of 3 months.

Initial authorization: 5 months

Continuation Criteria

One additional 5-month treatment course will be approved if the following criteria are met:

1. Patient has persistent or recurring severe nodular after the first course of treatment.
2. It has been at least 2 months since the discontinuation of the first treatment course.

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax.

Updated 04/2017
Last reviewed 05/2018

PriorityHealth

New request
Priority Health Precertification Documentation

A. Patient has severe, recalcitrant nodular acne?

- ☐ Yes
- ☐ No
- ☐ *Other – the patient's condition is:* ____________________

Rationale for use: ____________________

B. Trial and failure to one oral antibiotic used consistently for a total of 3 months?

☐ Yes

Drug	Dose	Dates	Outcome
________	________	________	________
________	________	________	________

☐ No, rationale:
____

C. Trial and failure to one generic topical retinoid used consistently for 3 months in addition to the oral antibiotic?

☐ Yes

Drug	Dose	Dates	Outcome
________	________	________	________
________	________	________	________

☐ No, rationale:
____

Continuation

Priority Health Precertification Documentation

A. Patient has persistent or recurring severe nodular after the first course of treatment?

- ☐ Yes
- ☐ No

B. Has it been at least 2 months since the discontinuation of the first treatment course?

- ☐ Yes
- ☐ No

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