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.

Claravis® (isotretinoin)

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 10mg
- ☐ Claravis 20mg
- ☐ Claravis 30mg
- ☐ Claravis 40mg

Start date (or date of next dose): _____
Date of last dose (if applicable): _____
Dosing frequency: _____

Precertification Requirements – *The following information is required for authorization of Claravis:*

Patient must meet all of the following criteria:

1. Must be age 12 years and older.
2. Treatment of severe, recalcitrant nodular acne unresponsive to conventional therapy including conventional antibiotics.
3. Prescribed by a dermatologist
4. Trial and failure/intolerance to at least 2 oral antibiotics used consistently for a total of 6 months
5. Trial and failure/intolerance to a topical retinoid used consistently for 6 months.

Initial authorization: 5 months, with monthly office visits.

For continuation, patient must have met the following requirements:

1. Improvement or stability of condition.
2. Tolerance and adherence to regimen.

Note: Authorization for indications, dosing, or a route of administration 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 appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 02/2018
Last reviewed 05/2019

New request
Priority Health Precertification Documentation

A. Patient has severe, recalcitrant nodular acne?

☐ Yes
☐ No, *the patient's condition is:* _____
Rationale for use: _____

B. Trial and failure/intolerance to two oral antibiotics used consistently for a total of 6 months?

☐ Yes:

Drug	Dose	Dates	Outcome
_____	_____	_____	_____
_____	_____	_____	_____

☐ No, rationale:
_____
_____

C. Trial and failure/intolerance to a topical retinoid used consistently for 6 months?

☐ Yes:

Drug	Dose	Dates	Outcome
_____	_____	_____	_____
_____	_____	_____	_____

☐ No, rationale:
_____
_____

Continuation
Priority Health Precertification Documentation

A. Patient has shown improvement or stability of condition?

☐ Yes
☐ No
☐ *Other – the patient's condition is:* _____
Rationale for use: _____

B. Patient has demonstrated tolerance and adherence to regimen?

☐ Yes
☐ No

Additional information

Note: Initial authorization for 5 months, continuation can be reviewed after 2 months or more off therapy.

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