# RETINOIDS (TOPICAL)
## PRIOR AUTHORIZATION
PRESCRIBER FAX FORM

**Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.**

**The following documentation is REQUIRED.** Incomplete forms will be returned for additional information. For formulary information please visit *www.myprime.com*. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

**What is the priority level of this request?**

☐ Standard review
☐ Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

**Today's Date:**___________________

**PATIENT AND INSURANCE INFORMATION** **Date of Service (if differs from Today's Date):** __________________

| Patient Name (First): | Last: | M: | DOB (mm/dd/yyyy): |
|---|---|---|---|
| Patient Address: | City, State, Zip: | Patient Telephone: | |
| Member ID Number: | Group Number: | | |

**PRESCRIBER/CLINIC INFORMATION**

| Prescriber Name: | Prescriber NPI#: | Specialty: | Contact Name: |
|---|---|---|---|
| Clinic Name: | Clinic Address: | | |
| City, State, Zip: | Phone #: | Secure Fax #: | |

**PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST**

| Patient's Diagnosis: | |
|---|---|
| Medication Requested: | Strength: |
| Dosing Schedule: | Quantity per Month: |

**For all requests:**

1. Is the patient currently treated with the requested agent?........................................ ☐ Yes ☐ No
   If yes, is the patient currently stable on the requested agent? **Please note, chart notes are required**.......... ☐ Yes ☐ No
2. Does the patient have any FDA labeled contraindications to the requested agent? ........................................ ☐ Yes ☐ No
   If yes, please specify contraindication(s):_______________________________________________
   _______________________________________________
   _______________________________________________
3. Is the patient using the requested agent for treatment of wrinkles, stretch marks, age spots, or skin lightening?........................................ ☐ Yes ☐ No
4. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** ___________________________
   _______________________________________________
   _______________________________________________
   _______________________________________________
   _______________________________________________

**Please continue to the next page.**

| Patient Name (First): | Last: | M: | DOB (mm/dd/yyyy): |
|---|---|---|---|

**For brand retinoid requests:**

- **Please submit chart notes to support the answers to the following questions:**

5. Has the patient tried and had an inadequate response to a generic topical retinoid? ☐ Yes ☐ No
6. Was a generic topical retinoid discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
7. Does the patient have an intolerance or hypersensitivity to a generic topical retinoid that is NOT expected to occur with the requested agent? ☐ Yes ☐ No
8. Does the patient have an FDA labeled contraindication to ALL generic topical retinoids that is NOT expected to occur with the requested agent? ☐ Yes ☐ No
9. Is a generic topical retinoid expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? ☐ Yes ☐ No
10. Is a generic topical retinoid NOT in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
11. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as a generic topical retinoid and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No


**Please fax or mail this form to:**
Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road Suite 200
Eagan, MN 55121

**TOLL FREE**

**Phone:** **Fax: 877.243.6930**
**BCBSIL: 800.285.9426**
**BCBSMT: 888.723.7443**
**BCBSNM: 800.544.1378**
**BCBSOK: 800.991.5643**
**BCBSTX: 800.289.1525**



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