

ACNE AGENTS, ORAL PRIOR AUTHORIZATION FORM

Prior authorization guidelines for Acne Agents, Oral are available on the DHS Pharmacy Services website at
<https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	total # of pgs: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			NPI:	State license #:
LTC facility contact/phone:			Street address:	
Beneficiary name:			Suite #:	City/state/zip:
Beneficiary ID#:		DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:
Dose/directions:	Quantity:
Duration of treatment:	Beneficiary's weight:
Diagnosis (<i>submit documentation</i>):	Dx code (<i>required</i>):
Does the beneficiary have a diagnosis of severe acne?	<input type="checkbox"/> Yes – <i>Submit documentation of diagnosis.</i> <input type="checkbox"/> No – <i>Submit medical literature supporting the use of the requested medication for the beneficiary's diagnosis.</i>
Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the following? Check all that apply. <input type="checkbox"/> topical antibiotics (e.g., clindamycin, erythromycin, sulfacetamide) <input type="checkbox"/> oral antibiotics (e.g., doxycycline, minocycline) <input type="checkbox"/> topical tretinoin (e.g., Avita, Altreno, Retin-A)	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit all supporting documentation of other medications tried and treatment outcomes, including contraindications or intolerances.</i>
For a non-preferred Acne Agent, Oral: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred Acne Agents, Oral? Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in each class.	<input type="checkbox"/> Yes <input type="checkbox"/> No <i>Submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances.</i>

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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