FAX Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

Request for Prior Authorization
ISOTRETINOIN (ORAL)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Preferred

☐ Amnesteem ☐ Claravis ☐ Myorisan ☐ Zenatane

Non-Preferred

☐ Absorica

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis:_____ Date of Initial Treatment: _____

*If PA extension, please specify exact date range of last drug-free interval: From: _____To:_____

Documentation of trial failures with systemic antibiotic & vitamin A derivative:

Systemic Antibiotic Drug Trial: Drug Name & Dose_____ Trial Dates:_____

Failure Reason_____

Vitamin A Derivative Drug Trial: Drug Name & Dose:_____ Trial Dates:_____

Failure Reason_____

Is patient enrolled in iPLEDGE program and meets all program requirements? ☐ No ☐ Yes

Reason for use of Non-Preferred drug requiring prior approval:_____

Other medical conditions to consider:_____

Possible drug interactions/conflicting drug therapies:_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*