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
TOPICAL ACNE AND ROSACEA PRODUCTS

(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

Prior authorization (PA) is not required for preferred topical acne agents (topical antibiotics and topical retinoids) for members under 21 years of age. PA is required for preferred topical acne agents for members 21 years or older, non-preferred topical acne agents and all topical rosacea agents. Payment will be considered under the following conditions:

1) Documentation of diagnosis; and
2) For the treatment of acne vulgaris, benzoyl peroxide is required for use with a topical antibiotic or topical retinoid; and
3) Payment for non-preferred topical acne products will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred topical acne agents of a different chemical entity from the requested topical class (topical antibiotic or topical retinoid); and
4) Payment for non-preferred topical rosacea products will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred topical rosacea agent; and
5) Requests for non-preferred combination products may only be considered after documented trials and therapy failures with two preferred combination products; and
6) Requests for topical retinoid products for skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive approval with documentation of submitted diagnosis; and
7) Duplicate therapy with agents in the same topical class (topical antibiotic or topical retinoid) will not be considered.

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

Preferred	**Non-Preferred**		
☐ Adapalene Gel	☐ Acanya	☐ BenzaClin	☐ MetroCream
☐ Avita Gel	☐ Aczone	☐ Benzamycin	☐ Metronidazole Gel & Lotion
☐ Azelex	☐ Adapalene/Benzoyl Peroxide	☐ Cleocin T	☐ Noritate
☐ Clindamycin	☐ Adapalene Cream/Sol	☐ Clindamycin Phosphate-Tretinoin	☐ Onexton
☐ Clindamycin/BPO	☐ Aklief	☐ Duac	☐ Plixda Pads
☐ Differin	☐ Altreno Lotion	☐ Epsolay	☐ Retin-A Micro
☐ Epiduo	☐ Amzeeq	☐ Erythromycin/BPO	☐ Sodium Sulfa/Sulf
☐ Erythromycin	☐ Arazlo	☐ Fabior	☐ Soolantra
☐ MetroGel 1%	☐ Atralin	☐ Finacea	☐ Tretinoin
☐ MetroLotion	☐ Avita Cream	☐ Ivermectin cream	☐ Twyneo
☐ Metronidazole 0.75% Cream	☐ Azelaic Acid Gel 15%	☐ Klaron	☐ Ziana
☐ Retin-A	☐ Other (specify)		☐ Zilxi
☐ Tazarotene Cream			
☐ Tazorac			

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Strength	Dosage Form	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

If acne vulgaris, document concurrent benzoyl peroxide use:

Drug Name & Strength: _____

Dosing Instructions: _____ Start date: _____

Non-Preferred Topical Acne or Rosacea Products

Acne Diagnosis: Document trials with two preferred topical acne agents of a different chemical entity; if a non-preferred combination product is requested, the two trials must be preferred topical acne combination products

Rosacea diagnosis: Document trial with one preferred topical rosacea agent of a different chemical entity:

Preferred Trial 1: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Preferred Trial 2: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Medical or contraindication reason to override trial requirements: _____

_____

Other relevant information: _____

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.*