UnitedHealthcare Community Plan

Dermatologics: Acne Products – Isotretinoin - Washington

Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Apple Health Preferred Drug list: https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: ______________

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: ______________

Section B - Provider Information

First Name:		Last Name: M.D./D.O.		
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? ______________

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:
Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   a. If yes, has the patient been experiencing recurrent or persistent moderate to severe acne or rosacea? ☐ Yes ☐ No
   b. If yes, is there documentation showing a positive clinical response? ☐ Yes ☐ No
2. Indicate the patient's diagnosis:
   ☐ Moderate to severe acne
   ☐ Moderate to severe rosacea
   ☐ Other. Specify: ____
3. Are the provider and patient enrolled in the iPLEDGE Risk Evaluation and Mitigation Strategy (REMS) program?
   ☐ Yes ☐ No
4. For non-preferred isotretinoin products: Has the patient tried and failed at least two (2) preferred isotretinoin products?
   ☐ Yes, specify the isotretinoin products and duration: ____
   ☐ Preferred isotretinoin product is not tolerated. Specify: ____
   ☐ Other. Specify: ____
5. Indicate patient's current weight: ________ kg Date taken: ___________

For diagnosis of moderate to severe acne

6. Has the patient tried and failed any of the following in combination with topical benzoyl peroxide or a topical retinoid (i.e. tretinoin) with a duration of use of at least 1 month? (Check all that apply)
   ☐ Oral antibiotics (i.e. doxycycline, erythromycin, trimethoprim-sulfamethoxazole)
   ☐ Benzoyl peroxide
   ☐ Topical retinoid (i.e. tretinoin)
   ☐ **For female patients**: Oral contraceptives (excludes progestin-only products)
   ☐ **For female patients**: Spironolactone
   ☐ Other. Specify: ____
   ☐ None of the above
7. Has the patient previously been treated with a full course of isotretinoin for acne? ☐ Yes ☐ No
   If yes, has it been at least 2 months since completion of the previous treatment? ☐ Yes ☐ No

For diagnosis of moderate to severe rosacea

8. Has the patient tried and failed any of the following in combination with oral antibiotics (i.e. doxycycline, clarithromycin, metronidazole) with a duration of use of at least 1 month? (Check all that apply)
   ☐ Topical ivermectin
   ☐ Topical antibiotics (i.e. metronidazole)
   ☐ Other. Specify: ____
   ☐ None of the above

REQUIRED WITH THIS REQUEST:

- Chart notes
- Labs
- Diagnostic tests results

Prescriber signature	Prescriber specialty	Date

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