UnitedHealthcare Community Plan

Isotretinoin
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.

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:
NPI #:	Phone:	Fax:	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 for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS:

- What is the patient's diagnosis? (check which applies)

□ Severe recalcitrant nodular acne unresponsive to conventional therapy
□ Treatment resistant acne
□ None of the above, **List diagnosis:** _____

- Does the patient have a history of failure, contraindication, or intolerance to an adequate trial with any of the following conventional therapy regimens: □ Yes □ No (check which applies)
(If yes, complete Section D above with medication information, including dose, date of trial, and reason for discontinuation)
□ Topical retinoid or retinoid-like agent [e.g. Retin-A/Retin-A Micro (tretinoin)]
□ Oral antibiotic [e.g. Ery-Tab (erythromycin), Biaxin (clarithromycin), Minocin (minocycline)]
□ Topical antibiotic with or without benzoyl peroxide [e.g. Cleocin-T (clindamycin), erythromycin, BenzaClin (benzoyl peroxide/clindamycin), Benzamycin (benzoyl peroxide/erythromycin)]

Requests for CONTINUATION OF THERAPY:

- Has the patient been off therapy for ≥ 2 months? □ Yes □ No
If yes, list date last taken: _____

- Is persistent or recurrent severe recalcitrant nodular acne still present? □ Yes □ No

- What is the total cumulative dose? _____ **Total Duration:** _____

- Patient's Weight: _____

Provider Signature: _____ **Date:** _____