CAREFIRST DC
Differin

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 855-582-2038 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Differin.

Patient Information

Patient Name:

Patient Phone: ☐☐☐-☐☐☐-☐☐☐☐

Patient ID:

Patient Group:

Patient DOB: ☐☐/☐☐/☐☐☐☐

Physician Information

Physician Name

Physician Phone: ☐☐☐-☐☐☐-☐☐☐☐

Physician Fax: ☐☐☐-☐☐☐-☐☐☐☐

Physician Addr.:

City, St, Zip:

Drug Name (specify drug)

_____

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

_____

Please check the appropriate answer for each applicable question.

1.	Is the requested drug being prescribed for the topical treatment of acne vulgaris?	**Y** ☐	**N** ☐
2.	Is the request for continuation of therapy?	**Y** ☐	**N** ☐
3.	Has the patient achieved or maintained a positive response to the requested drug as evidenced by improvement (e.g., reduction in number of lesions, etc.)?	**Y** ☐	**N** ☐
4.	Is the requested drug being prescribed to treat a body surface area that requires MORE than any of the following per 4 weeks: A) 120 milliliters of adapalene topical solution, B) 45 grams of Differin cream or gel (adapalene cream, gel), C) 59 milliliters of Differin lotion (adapalene lotion), D) 28 swabs of adapalene topical solution?	**Y** ☐	**N** ☐
5.	Does the patient require MORE than the plan allowance per 4 weeks of any of the following: A) 240 milliliters of adapalene topical solution, B) 90 grams of Differin cream or gel (adapalene cream, gel), C) 118 milliliters of Differin lotion (adapalene lotion), D) 56 swabs of adapalene topical solution?	**Y** ☐	**N** ☐
6.	Is the requested drug being prescribed to treat a body surface area that requires MORE than any of the following per 4 weeks: A) 120 milliliters of adapalene topical solution, B) 45 grams of Differin cream or gel (adapalene cream, gel), C) 59 milliliters of Differin lotion (adapalene lotion), D) 28 swabs of adapalene topical solution?	**Y** ☐	**N** ☐
7.	Does the patient require MORE than the plan allowance per 4 weeks of any of the following: A) 240 milliliters of adapalene topical solution, B) 90 grams of Differin cream or gel (adapalene cream, gel), C) 118 milliliters of Differin lotion (adapalene lotion), D) 56 swabs of adapalene topical solution?	**Y** ☐	**N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

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Prescriber (Or Authorized) Signature and Date