PA Request Criteria

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178997

CAREFIRST - MD EXCHANGE 5T
Isotretinoins (HMF)

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 855-582-2022 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Isotretinoins (HMF).

Patient Name: _____ **Date:** 11/28/2023
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**

Drug Name (select from list of drugs shown)

Accutane (isotretinoin)	Amnesteem (isotretinoins)	Claravis (isotretinoin)
Isotretinoin	Myorisan (isotretinoin)	Zenatane (isotretinoin)

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

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

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1. Does the patient have any of the following diagnoses: A) severe recalcitrant nodular acne vulgaris, B) refractory acne vulgaris, C) severe refractory rosacea? **Y** ☐ **N** ☐

2. Has the patient tried and had an inadequate treatment response to any topical acne product AND an oral antibiotic? **Y** ☐ **N** ☐
   Note: Topical products include salicylic acid, benzoyl peroxide, azelaic acid, adapalene, tretinoin, tazarotene, clindamycin, erythromycin, or metronidazole for rosacea. Oral antibiotics include minocycline, doxycycline, tetracycline, erythromycin, trimethoprim-sulfamethoxazole, trimethoprim, azithromycin.

3. Will treatment be limited to 40 weeks (2 courses) or less AND with at least 8 weeks between each course? **Y** ☐ **N** ☐

4. Does the patient have any of the following diagnoses: A) neuroblastoma, B) cutaneous T-cell lymphoma (CTCL) (e.g., mycosis fungoides, Sezary syndrome), C) is at high risk for developing skin cancer (squamous cell cancers), D) transient acantholytic dermatosis (Grover's Disease), E) keratosis follicularis (Darier Disease), F) lamellar ichthyosis, G) pityriasis rubra pilaris? **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.

_____

Prescriber (Or Authorized) Signature and Date

Effective July 1, 2015, Maryland law will require providers to submit pharmaceutical preauthorization requests electronically. To use ePA, either contact your electronic health record vendor or visit www.covermymeds.com/epa/caremark