



**BlueCross
BlueShield**

Federal Employee Program. **TRETINOIN
PRIOR APPROVAL REQUEST**

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: **1-877-378-4727**

Patient Information (required)				Provider Information (required)		
Date:				Provider Name:		
Patient Name:				Specialty:		NPI:
Date of Birth:	Sex: ☐ Male ☐ Female			Office Phone:		Office Fax:
Street Address:				Office Street Address:		
City:	State:	Zip:		City:	State:	Zip:
Patient ID:	R			Physician Signature:		
PHYSICIAN COMPLETES						

Tretinoin

Prior approval is **NOT REQUIRED** for these agents if the patient is between the ages of 9 and 34

NOTE: Form must be completed in its **entirety** for processing

Please select medication:

- | | | |
|---|--|--|
| ☐ Akliel (trifarotene) | ☐ Epiduo (adapalene/benzoyl peroxide) | ☐ Tretinoin powder |
| ☐ Altreno (tretinoin) | ☐ Refissa (tretinoin) | ☐ Twynco (tretinoin/benzoyl peroxide) |
| ☐ Atralin (tretinoin) | ☐ Renova 0.05% [†] (tretinoin) | ☐ Veltin (tretinoin/clindamycin) |
| ☐ Avita (tretinoin) | ☐ Retin-A (tretinoin) | ☐ Ziana (tretinoin/clindamycin phosphate) |
| ☐ Differin (adapalene) | ☐ Tretin-X (tretinoin) | |

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

[†] Renova 0.02% is not a covered benefit, as its only FDA approved indication is for cosmetic use

Is this request for brand or generic? ☐ Brand ☐ Generic

1. What is the patient's diagnosis?

- ☐ Acne conglobata
- ☐ Acne vulgaris
- ☐ Actinic keratosis
- ☐ Basal cell carcinoma
- ☐ Comedones
- ☐ Cysts (eruptive vellus hair cyst, cystic acne)
- ☐ Papules
- ☐ Pustules
- ☐ Rosacea or acne rosacea
- ☐ Squamous cell carcinoma
- ☐ Other diagnosis (*please specify*): _____

2. Actinic Keratosis, Basal Cell Carcinoma, or Squamous Cell Carcinoma Diagnosis: Is the patient considered high risk due to concurrent conditions such as being immunocompromised or post organ transplant? ☐ Yes* ☐ No

***If YES, please select answer below:**

- ☐ High risk and is immunocompromised ☐ High risk and is post organ transplant
- ☐ High risk due to another reason (*please specify*): _____



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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 minutes FASTEST AND EASIEST	Now you can get responses to drug prior authorization requests securely online. Online submissions may receive instant responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to Caremark.com/ePA.
Phone (4-5 minutes for response)	The FEP Clinical Call Center can be reached at (877)-727-3784 between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same info contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 days for response)	Fax the attached form to (877)-378-4727 Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the PA request cannot be processed. <u>Please only fax the completed form once as duplicate submissions may delay processing times.</u>

faster...

easier...

better...

Introducing ePA! Online Prior Authorizations in minutes through **Caremark.com/ePA**. Sign up today!

CVS/caremark

