Request for Prior Authorization

TOPICAL ACNE AND ROSACEA PRODUCTS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

Fax Completed Form To
1.833.404.2392
Prescriber Help Desk
1.833.587.2012
Online
covermymeds.com/main/prior-authorization-forms/

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is not required for preferred topical acne agents (topical antibiotics and topical retinoids) for members under 21 years of age. PA is required for preferred topical acne agents for members 21 years or older, non-preferred topical acne agents and all topical rosacea agents. Payment will be considered when member has an FDA approved or compendia indication for the requested drug, except for any drug or indication excluded from coverage, as defined in Section 1927 (2)(d) of the Social Security Act, Iowa's CMS approved State Plan, and the Iowa Administrative Code (IAC) when the following conditions are met:

1) Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and
2) Documentation of diagnosis; and
3) For the treatment of acne vulgaris, benzoyl peroxide is required for use with a topical antibiotic or topical retinoid; and
4) Payment for non-preferred topical antibiotic or topical retinoid acne products will be authorized only for cases in which there is documentation of previous trials and therapy failures with two preferred topical acne agents of a different chemical entity from the requested topical class (topical antibiotic or topical retinoid); and
5) Payment for non-preferred topical acne products outside of the antibiotic or retinoid class (e.g., Winlevi) will be authorized only for cases in which there is documentation of previous trials and therapy failures with a preferred topical retinoid and at least two other topical acne agents. If criteria for coverage are met, initial requests will be approved for six months; and
6) Payment for non-preferred topical rosacea products will be authorized only for cases in which there is documentation of a previous trial and therapy failure with a preferred topical rosacea agent; and
7) Requests for non-preferred combination products may only be considered after documented trials and therapy failures with two preferred combination products; and
8) Requests for topical retinoid products for skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive approval with documentation of submitted diagnosis; and
9) Duplicate therapy with agents in the same topical class (topical antibiotic or topical retinoid) will not be considered.

The required trials may be overridden when documented evidence is provided that the use of these agents would be medically contraindicated.

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Preferred	Non-Preferred		
Adapalene/BPO 0.1-2.5%	Acanya	Cleocin T	Metronidazole Gel & Lotion
Adapalene Gel	Adapalene/BPO 0.3-2.5%	Clindagel	Noritate
Avita Gel	Adapalene/BPO Pad	Clindamycin/BPO 1.2-5%	Onexton
Clindamycin	Adapalene Cream	Clindamycin Foam	Retin-A Micro
Clindamycin/BPO 1.2-2.5%	Altreno Lotion	Clindamycin Phosphate-Tretinoin	Sodium Sulfa/Sulf
Erythromycin	Arazlo	Dapsone Gel	Tretinoin
Metronidazole 0.75% Cream	Atralin	Erythromycin/BPO	Winlevi
Retin-A	Avita Cream	Fabior	Ziana
Tazarotene Cream & Gel	Azelaic Acid Gel 15%	Finacea	
	Benzamycin	Ivermectin cream	
	Cabtreo	Klaron	
	Other (specify)		

Strength	Dosage Form	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

If acne vulgaris, document concurrent benzoyl peroxide use:

Drug Name & Strength: _____

Dosing Instructions: _____ Start date: _____

Non-Preferred Topical Acne or Rosacea Products

Acne Diagnosis: Document trials with two preferred topical acne agents of a different chemical entity; if a non-preferred combination product is requested, the two trials must be preferred topical acne combination products

Rosacea diagnosis: Document trial with one preferred topical rosacea agent of a different chemical entity:

Preferred Trial 1: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Preferred Trial 2: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Requests for Non-Preferred Agents outside of antibiotic or retinoid class (e.g, Winlevi):

Preferred Topical Retinoid: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Trial 2: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Trial 3: Name/Dose: _____ Trial Dates: _____

Failure reason: _____

Medical or contraindication reason to override trial requirements: _____

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Other relevant information:_____

Possible drug interactions/conflicting drug therapies:_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*