Atralin[®], Retin-A[®], Retin-A Micro[®], Veltin[®] & Ziana[®]

Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.

This form may be faxed to 844-403-1029.

Member Information (required)			Pr	Provider Information (required)			
Member Name:			Provider Name	Provider Name:			
Insurance ID#:			NPI#:		Specialty:		
Date of Birth:			Office Phone:	Office Phone:			
Street Address	S:		Office Fax:	Office Fax:			
City:	State:	ZIP:	Office Street A	Office Street Address:			
Phone:			City:	State:	ZI	P:	
		Medicatio	on Information	(required)			
Medication Name:			Strength:	th: Dosage Form:		:	
			Directions for Use:				
		Clinical	Information (req	quired)			
1. Does the patient have a diagnosis of keratosis follicularis (Darier's disease, Darier-White disease)?						🛛 Yes 🖾 No	
2. Does the patient have a diagnosis of acne vulgaris?						🗆 Yes 🗅 No	
3. If the patie	ent does not have any	of the above diagno	oses, list the patient's o	diagnosis:			
4. Has the patient tried and failed a generic topical tretinoin product?						🛛 Yes 🖵 No	
5. Does the prescriber deem that a generic topical tretinoin product would be inappropriate for the patient?						🗆 Yes 🗅 No	

Information on this form is accurate as of this date.

Prescriber's Signature:	Date:

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

<u>Please note</u>: **This request may be denied unless all required information is received.** For more information about the prior authorization process, please contact us at 855-811-2218. Monday – Friday: 8 a.m. to 1 a.m. Eastern, and Saturday: 9 a.m. to 6 p.m. Eastern

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