OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.

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Fabior® Prior Authorization Request Form

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

Meml	per Informati	ion (required)	Pro	ovider Info	rmation (red	quired)	
Member Name:				Provider Name:			
Insurance ID#:			NPI#:	NPI#:		Specialty:	
Date of Birth:			Office Phone:	Office Phone:			
Street Address:			Office Fax:	Office Fax:			
City:	State:	ZIP:	Office Street Ad	Office Street Address:			
Phone:			City:	State: ZIF		:	
		Medication	Information (re	equired)			
Medication Name:			Strength:	squireay	Dosage Form:		
			Directions for U	se:			
						*	
		Clinical In	formation (requ	uired)			
1. Does the patient have a diagnosis of acne vulgaris?						☐ Yes ☐ No	
2. Has the patient tried and failed a generic topical tretinoin product?						☐ Yes ☐ No	
3. Does the prescriber deem that a generic topical tretinoin product would b				inappropriate fo	r the patient?	☐ Yes ☐ No	
4. Is the patient a female and has child-bearing capabilities (e.g., no hysterectomy, has and has not reached menopause)?					ved menses	☐ Yes ☐ No	
5. Has the prescriber discussed with the patient the potential risks of fetal harm and the need to avoid pregnancy or use birth control while using tazarotene products?						☐ Yes ☐ No	
Information on this f	orm is accurate as	of this date.					
Prescriber's Sign	ature:		D	ate:			
Are there any other corthis review?	nments, diagnoses, s	symptoms, medications t	ried or failed, and/or ar	ny other informatio	on the physician fe	els is important to	
For mor	re information about the	unless all required informed prior authorization proce	ss, please contact us at				

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