AmeriHealth Caritas Iowa

AmeriHealth Caritas Iowa
Request for Prior Authorization
Topical Acne and Rosacea Products

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
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 is required for topical acne agents (topical antibiotics and topical retinoids) and topical rosacea agents. Payment for topical acne and topical rosacea agents will be considered under the following conditions:

1. Documentation of diagnosis.
2. For the treatment of acne vulgaris, benzoyl peroxide is required for use with a topical antibiotic or topical retinoid for moderate to severe acne.
3. Payment for non-preferred topical 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).
4. 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.
5. Requests for non-preferred combination products may only be considered after documented trials and therapy failures with two preferred combination products.
6. Requests for topical retinoid products for skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive approval with documentation of submitted diagnosis.
7. Trial and therapy failure with a preferred topical antipsoriatic agent will not be required for the preferred tazarotene (Tazorac) product for a psoriasis diagnosis.
8. 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.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult **www.iowamedicaidpdl.com/pa_criteria**.

Preferred

- ☐ Acanya
- ☐ Adapalene gel
- ☐ Azelex
- ☐ Benzoyl Peroxide 7% cleanser
- ☐ Clindamycin
- ☐ Differin cream, gel, and lotion
- ☐ Epiduo
- ☐ Erythromycin
- ☐ MetroGel 1%
- ☐ MetroLotion
- ☐ Metronidazole 0.75% cream
- ☐ Retin-A
- ☐ Tazorac

Non-Preferred

- ☐ Aczone
- ☐ Adapalene
- ☐ Atralin
- ☐ BenzaClin
- ☐ BenzaClin pump
- ☐ Benzamycin
- ☐ Benzamycin Pak
- ☐ Cleocin T
- ☐ Clindamycin/BPO
- ☐ Clindamycin phosphate-tretinoin
- ☐ Duac
- ☐ Erythromycin/BPO
- ☐ Fabior
- ☐ Finacea
- ☐ Klaron
- ☐ MetroCream
- ☐ Metronidazole gel and lotion
- ☐ Noritate
- ☐ Onexton
- ☐ Retin-A Micro
- ☐ Rosanil cleanser
- ☐ Sodium Sulfa/Sulf
- ☐ Soolantra
- ☐ Tretinoin
- ☐ Veltin
- ☐ Ziana
- ☐ Other (specify):

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Dosage instructions:

Strength: Dosage form: Quantity: Days supply:

Diagnosis:

If acne vulgaris, document concurrent benzoyl peroxide use.

Drug name and dose: Start date:

Dosing instructions:

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: Drug name and dose: Trial dates:

Failure reason:

Preferred Trial 2: Drug name and dose: Trial dates:

Failure reason:

Medical or contraindication reason to override trial requirements:

Other relevant information:

Possible drug interactions/conflicting drug therapies:

Attach lab results and other documentation as necessary.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste, and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.

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 Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/provider to confirm your version of this form.