ProCare Rx

Isotretinoin®

Ticket #: ____________________ Request Date: ____________________ Request Time: ____________________

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of **Isotretinoin®**. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information		
Patient Name:	Plan Name/Plan ID:	
Patient ID:	Patient Date of Birth:	Patient Contact Phone #:

B. Physician Information			
Physician Name:	Physician Address:		
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC #:

C. Pharmacy Information			
Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:

D. Clinical Information (Please fill out the following information: circle all that apply)

1. Please select diagnosis below: **(Must provide ICD-9/10 code and progress notes/medical record indicating diagnosis.)**
   - ☐ Acne (e.g., severe recalcitrant nodular acne, severe acne, cystic acne)
     ICD-9/10 Code(s): ____________________
   - ☐ Other diagnosis: ____________________
     ICD-9/10 Code(s): ____________________
2. Has patient had a failure, contraindication or intolerance to any of the medications listed below? (check all that apply) YES NO

   Must have had an adequate trial of 6 or more weeks.
   - ☐ A topical retinoid or retinoid-like agent [e.g. Retin-A/Retin-A Micro (tretinoin)]
   - ☐ Benzoyl peroxide and an oral antibiotic [e.g. Ery-Tab (erythromycin), Minocine (minocycline)]
   - ☐ Benzoyl peroxide and a topical antibiotic [e.g. Cleocin-T (clindamycin), erythromycin, BenzaClin (benzoyl peroxide/clindamycin), Benzamycin (benzoyl peroxide/erythromycin)]
3. Is this medication being prescribed by a dermatologist? YES NO

Authorized Medical Signature:	
Telephone:	**Date:**

When Completed Return To:

ProCare PBM Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.