OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Isotretinoin Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:
❑ Acne
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Prescriber specialty:
Is the requested medication being prescribed by a dermatologist? ❑ **Yes** ❑ **No**

Select the medications the patient has a trial and failure, contraindication, or intolerance to after an adequate trial (at least 6 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), Minocin (minocycline)]
❑ Benzoyl peroxide and a TOPICAL antibiotic [e.g., Cleocin-T (clindamycin), erythromycin, BenzaClin (benzoyl peroxide/clindamycin), Benzamycin (benzoyl peroxide/erythromycin)] (if oral antibiotics are not indicated)

Reauthorization:
If this is a reauthorization request, answer the following:
After greater than 2 months **OFF** therapy, is persistent or recurring acne still present? ❑ **Yes** ❑ **No**
What is the patient's weight? _____
What is the patient's total cumulative dose (mg/kg) for the total duration of therapy? _____

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

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.