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

Retinoids (Topical) 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 vulgaris (i.e., acne)
❑ Actinic keratosis
❑ Alopecia areata
❑ Hyperkeratosis
❑ Keloid Scar
❑ Systematized epidermal nevus
❑ Wound healing (mild)
❑ Other diagnosis: ______________________________ ICD-10 Code(s): _____________________________________

Clinical information:

Is the medication being requested solely for cosmetic purposes (e.g., photoaging, wrinkling, hyperpigmentation, sun damage, melasma)? ❑ **Yes** ❑ **No**

Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Atralin gel
❑ Avita cream
❑ Avita gel
❑ Epiduo
❑ Epiduo Forte
❑ Onexton
❑ OTC Differin gel
❑ Tretinoin cream
❑ Tretinoin gel
❑ Tretinoin microsphere gel
❑ Other retinoid product(s). Please specify: ____

Quantity limit requests:

What is the quantity requested per MONTH? _________

Does the patient require a greater quantity for the treatment of a larger surface area? ❑ **Yes** ❑ **No**

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.

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**
Office use only: Retinoids_Comm_2019Jan1-W