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Visit [go.covermymeds.com/OptumRx](http://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

## Atralin® (tretinoin gel) Prior Authorization Request Form

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

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
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 <small>(required)</small>			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>		Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			

Clinical Information <small>(required)</small>	
<b>Select the diagnosis below:</b>	
<input type="checkbox"/> Acne vulgaris (i.e., acne)	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	

<p><b>Select the medications the patient has a failure, contraindication, or intolerance to:</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Acanya</li> <li><input type="checkbox"/> Adapalene and benzoyl peroxide</li> <li><input type="checkbox"/> Adapalene cream</li> <li><input type="checkbox"/> Adapalene gel</li> <li><input type="checkbox"/> Adapalene solution</li> <li><input type="checkbox"/> Aktipak</li> <li><input type="checkbox"/> Benzamycin</li> <li><input type="checkbox"/> Clindamycin-benzoyl peroxide 1-5%</li> <li><input type="checkbox"/> Clindamycin-benzoyl peroxide 1.2-5%</li> <li><input type="checkbox"/> Differin</li> <li><input type="checkbox"/> Epiduo</li> <li><input type="checkbox"/> Epiduo Forte</li> <li><input type="checkbox"/> Erythromycin-benzoyl peroxide</li> <li><input type="checkbox"/> Fabior</li> <li><input type="checkbox"/> Neuac</li> <li><input type="checkbox"/> Onexton</li> <li><input type="checkbox"/> Plixda</li> <li><input type="checkbox"/> Retin A Micro</li> <li><input type="checkbox"/> Retin A Micro Pump</li> <li><input type="checkbox"/> Tazarotene</li> <li><input type="checkbox"/> Tazorac</li> <li><input type="checkbox"/> Tretinoin 0.01% gel</li> <li><input type="checkbox"/> Tretinoin 0.025% gel</li> <li><input type="checkbox"/> Tretinoin cream</li> </ul>
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**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.  
 If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.  
 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: Atralin-TretinoinGel\_CMS\_2019Feb-W