



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

Retin-A[®] (tretinoin), Retin-A Micro[®] (tretinoin microsphere gel), Retin-A Micro Pump[®] (tretinoin microsphere pump) 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 brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information <small>(required)</small>	
Select the diagnosis below:	
<input type="checkbox"/> Acne vulgaris (i.e., acne)	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	
Select the medications the patient has a failure, contraindication, or intolerance to:	
<input type="checkbox"/> Acanya <input type="checkbox"/> Adapalene and benzoyl peroxide <input type="checkbox"/> Adapalene cream <input type="checkbox"/> Adapalene gel <input type="checkbox"/> Adapalene solution <input type="checkbox"/> Aktipak <input type="checkbox"/> Benzamycin <input type="checkbox"/> Clindamycin-benzoyl peroxide 1-5% <input type="checkbox"/> Clindamycin-benzoyl peroxide 1.2-5% <input type="checkbox"/> Differin <input type="checkbox"/> Epiduo <input type="checkbox"/> Epiduo Forte	<input type="checkbox"/> Erythromycin-benzoyl peroxide <input type="checkbox"/> Fabior <input type="checkbox"/> Neuac <input type="checkbox"/> Onexton <input type="checkbox"/> Plixda <input type="checkbox"/> Retin-A Micro 0.06% gel <input type="checkbox"/> Retin-A Micro Pump 0.08% gel <input type="checkbox"/> Tazarotene <input type="checkbox"/> Tazorac <input type="checkbox"/> Tretinoin cream <input type="checkbox"/> Tretinoin gel

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.

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