Dermatologics: Acne Products – Isotretinoin

Please fax this completed form to (833) 645-2734 OR mail to: Pharmacy Services| 5 River Park Place East, Suite 210 | Fresno, CA 93720. You can also complete online at CoverMyMeds.com.

Coordinated Care of Washington. Inc. Preferred Drug list: *https://www.coordinatedcarehealth.com/content/dam/centene/centene-pharmacy/pdl/FORMULARY-CoordinatedCare_Washington.pdf*

Date of request:	Reference #:	MAS:	
Patient	Date of birth	ProviderOne ID or Coordinated Care ID	
Pharmacy name	Pharmacy NPI	Telephone number	Fax number
Prescriber	Prescriber NPI	Telephone number	Fax number
Medication and strength	Directions for use	Qty/Days supply	

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   a. If yes, has the patient been experiencing recurrent or persistent moderate to severe acne or rosacea?
      ☐ Yes ☐ No
   b. If yes, is there documentation showing a positive clinical response? ☐ Yes ☐ No

2. Indicate the patient's diagnosis:
   ☐ Moderate to severe acne
   ☐ Moderate to severe rosacea
   ☐ Other. Specify:

3. Are the provider and patient enrolled in the iPLEDGE Risk Evaluation and Mitigation Strategy (REMS) program?
   ☐ Yes ☐ No

4. For non-preferred isotretinoin products: Has the patient tried and failed at least two (2) preferred isotretinoin products?
   ☐ Yes, specify the isotretinoin products and duration:
   ☐ Preferred isotretinoin product is not tolerated. Specify:
   ☐ Other. Specify:

5. Indicate patients current weight? _____ kg Date taken: _____

For diagnosis of moderate to severe acne

6. Has the patient tried and failed any of the following in combination with topical benzoyl peroxide or a topical retinoid (i.e. tretinoin) with a duration of use of at least 1 month? (Check all that apply)
   ☐ Oral antibiotics (i.e. doxycycline, erythromycin, trimethoprim-sulfamethoxazole)
   ☐ Benzoyl peroxide
   ☐ Topical retinoid (i.e. tretinoin)
   ☐ **For female patients**: Oral contraceptives (excludes progestin-only products)
   ☐ **For female patients**: Spironolactone
   ☐ Other. Specify:
   ☐ None of the above

7. Has the patient previously been treated with a full course of isotretinoin for acne? ☐ Yes ☐ No
   If yes, has it been at least 2 months since completion of the previous treatment? ☐ Yes ☐ No

For diagnosis of moderate to severe rosacea

8. Has the patient tried and failed any of the following in combination with oral antibiotics (i.e. doxycycline, clarithromycin, metronidazole) with a duration of use of at least 1 month? (Check all that apply)
   - ☐ Topical ivermectin
   - ☐ Topical antibiotics (i.e. metronidazole)
   - ☐ Other. Specify:
   - ☐ None of the above

REQUIRED WITH THIS REQUEST:

- Chart notes
- Labs
- Diagnostic tests results

Prescriber signature	Prescriber specialty	Date

Pharmacy Services will respond via fax or phone within 24 hours of receipt of the request. Requests for prior authorization must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)