

## 2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

## **Isotretinoins**

Fax back to: (833) 605-4407 Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

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Patient Name:	Prescriber Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):
REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I the enrollee or the enrollee's ability to regain maximum function.	certify that the standard review timeframe may seriously jeopardize the life or health of
Drug Name:	
Strength:	
Directions / SIG:	
Please attach any pertinent medical history including labs and information for this member that may support approval.  Please answer the following questions and sign.	
Q1. Does the patient have any of the following diagnoses: A) severe recalcitrant nodular acne vulgaris, B) refractory acne vulgaris, C) severe refractory rosacea?	
☐ Yes	□No
Q2. Has the patient tried and had an inadequate AND an oral antibiotic?	treatment response to any topical acne product
☐ Yes	□ No
Q3. Will treatment be limited to 40 weeks (2 cou each course?	rses) or less AND with at least 8 weeks between
☐ Yes	□No
Q4. Does the patient have any of the following diagnoses: A) neuroblastoma, B) cutaneous T-cell lymphoma (CTCL) (e.g., mycosis fungoides, Sezary syndrome), C) is at high risk for developing skin cancer (squamous cell cancers), D) transient acantholytic dermatosis (Grover's Disease), E) keratosis follicularis (Darier Disease), F) lamellar ichthyosis, G) pityriasis rubra pilaris?	
☐ Yes	□No
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Patient Name:	Prescriber Name:
Q5. Additional Information:	
Prescriber Signature	Date
	2024 Prior Authorization Request

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