SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Topical Acne Drugs – Dermatologic (Non-Preferred and/or 18 Years of Age or Older)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Preferred Medications: (Combo Benzoyl Peroxide, Clindamycin, Erythromycin & other Top)				
❑ Acne medication gel, lotion	❑ Benzoyl peroxide wash, cream, gel, lotion (OTC)	❑ clindacin ETZ 1% pledget	❑ clindamycin phosphate 1% solution	❑ clindamycin phosphate 1% pledget, swab
❑ Clindamycin phosphate 1% gel	❑ clindamycin phosphate 1% lotion	❑ clindamycin/ benzoyl peroxide (Duac®)	❑ erythromycin solution	❑ Panoxyl 4 Acne Cream Wash (OTC)
❑ Panoxyl 10				

Preferred Medications: (Retinoids/Combinations, Topical)	
❑ Adapalene 0.1% gel OTC	❑ Tretinoin 0.025., 0.05, 0.1 % cream & 0.025% gel/ Retin®A 0.025., 0.05, 0.1 % cream & 0.01, 0.025%gel

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Prior authorization for a cosmetic indication CANNOT be approved.
All Non-Preferred Medications and/or members 18 years of age or older Require a Prior Authorization

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- Is member 18 years of age or older? **(PA is required to evaluate treatment diagnosis. Drugs are intended** for **ACNE ONLY.)** ❑ Yes ❑ No

AND

- For **Non-Preferred** drugs, member has tried and failed at least **two (2) Preferred** drugs **from the corresponding class**. **(intended for ACNE ONLY.)** ❑ Yes ❑ No
- List previous medications below **(including name of drug and dose)**:

_____

_____

_____

_____

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

REVISED/UPDATED: ~~7/6/2017~~; ~~8/23/2017~~; ~~9/1/2017~~; ~~12/26/2017~~; ~~8/31/2018~~; ~~(Reformatted) 6/21/2019; 1/14/2020; 6/28/2022; 6/26/2023;~~ **9/26/2023**