SENTARA HEALTH PLANS

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 (check applicable box below)

PREFERRED	
❑ **adapalene** (Differin®) cream/gel/solution *Requires prior authorization if used as treatment in a member ≥ 29 years of age	❑ **tretinoin** (Retin®-A) **cream 0.025%, 0.05%, 0.1%; gel 0.01%, 0.025%** *Requires prior authorization if used as treatment in a member ≥ 29 years of age
NON-PREFERRED	
❑ **adapalene 0.3%/benzoyl peroxide 2.5% gel** (Epiduo Forte®)	❑ **Altreno®** (tretinoin) **lotion 0.05%**
❑ **Aklief®** (trifarotene) **cream 0.005%**	❑ **Amzeeq®** (minocycline) **topical foam 4%**
❑ **Azelex®** (azelaic acid) **cream 20%**	❑ **clindamycin 1.2%/benzoyl peroxide 2.5% gel** (Acanya®)
❑ **dapsone gel 5%** (Aczone®)	❑ **erythromycin 3%/benzoyl 5% gel** (Benzamycin®)
❑ **Retin®-A Micro** (tretinoin microsphere) **0.06%, 0.08% gel**	❑ **tazarotene** (Fabior®) **foam 0.1%**
❑ **tretinoin gel 0.05%** (Atralin®)	❑ **tretinoin microsphere gel 0.04%,0.1%** (Retin®-A Micro)
❑ **Winlevi®** (clascoterone) **cream 1%**	

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:** _____

NPI #: _____

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DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Weight (if applicable): _____ **Date weight obtained:** _____

***NOTE: adapalene and all tretinoin based medications are restricted to NON-COSMETIC purposes. Requests for cosmetic indications will be denied as BENEFIT EXCLUSIONS**

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.

For preferred adapalene or tretinoin product requests in member 29 years of age or older:

- ❑ Member must meet **ONE** of the following for generic adapalene or tretinoin requests:
  - ❑ Member has a diagnosis of acne vulgaris
  - ❑ Member has a diagnosis of rosacea
  - ❑ Member has a diagnosis of actinic keratosis (for generic tretinoin requests only)
  - ❑ Medication is being requested for a diagnosis not listed on prior authorization form and provider has submitted rationale for medical necessity of use with supporting clinical documentation

For all other topical acne drug requests:

- ❑ For all other topical acne drug requests, member must meet **BOTH** of the following:
  - ❑ Member has been diagnosed with acne vulgaris
  - ❑ Member must have documentation of at least a **30 day trial and failure** of **THREE (3)** of the following:
    - ❑ adapalene 0.1% cream/solution/gel or 0.3% gel (generic Differin®) ***PA required ≥ 29 y.o.***
    - ❑ adapalene 0.1%/benzoyl peroxide 2.5% gel (generic Epiduo®)
    - ❑ benzoyl peroxide OTC
    - ❑ benzoyl peroxide 1%, 1.2%/clindamycin 5% gel (generic BenzaClin® & Neuac®/Duac® gel)
    - ❑ clindamycin 1% topical
    - ❑ erythromycin 2% topical
    - ❑ tazarotene 0.1% cream
    - ❑ tretinoin (generic Retin-A®) 0.025%, 0.05%, 0.1% cream or 0.01%, 0.025% gel ***PA required ≥ 29 y.o.***

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Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****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.****

***Approved by Pharmacy and Therapeutics Committee**: ~~4/17/2014;~~ **9/26/2024**
REVISED/UPDATED/REFORMATTED: ~~5/8/2014; 5/28/2014; 6/10/2014; 7/29/2014; 8/6/2014; 9/23/2014; 11/5/2014; 2/19/2015; 5/27/2015; 7/23/2015; 8/11/2015; 10/19/2015; 12/29/2015; 4/21/2016; 5/6/2016; 12/20/2016; 8/18/2017; 6/19/2019; 11/11/2019; 6/24/2020; 6/30/2021; 4/25/2022; 6/15/2022; 6/16/2022; 10/24/2022; 10/27/2023;~~ **12/20/2024**