OPTIMA HEALTH PLAN

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 information provided is not complete, correct, or legible, authorization may be delayed.**

Drug Requested: Topical Acne Drugs (check applicable box below)

❑ **PREFERRED: adapalene** (Differin®) cream/gel/solution **	❑ **PREFERRED: tretinoin** (Retin®-A) **cream 0.025%, 0.05%, 0.1%; gel 0.01%, 0.025%****
****generic adapalene and tretinoin products require prior authorization if used as treatment in a member greater than 29 years of age**	
❑ **adapalene 0.3%/benzoyl peroxide 2.5% gel** (generic for 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®)	❑ **Fabior®** (tazarotene) **foam 0.1%**
❑ **Retin®-A Micro** (tretinoin microsphere) **0.06%, 0.08% gel**	❑ **tazarotene cream 0.1%** (Tazorac®)
❑ **tretinoin gel 0.05%** (Atralin®)	❑ **tretinoin microsphere gel 0.04%,0.1%** (Retin®-A Micro)
❑ **Winlevi®** (clascoterone) **cream 1%**	

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

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.

****NOTE: Adapalene and all tretinoin based medications are restricted to NON-COSMETIC purposes**

****generic adapalene and tretinoin products require prior authorization if used as treatment in a member greater than 29 years of age.**

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For formulary preferred adapalene or tretinoin product requests:

- ❑ If requesting a formulary preferred adapalene or tretinoin product, member has **ONE** of the following diagnoses
  - ❑ Diagnosis (for generic adapalene or tretinoin requests):
    - ❑ Acne vulgaris and member is greater than 29 years of age
    - ❑ Rosacea and member is greater than 29 years of age
    - ❑ 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 below
  - ❑ Diagnosis (for generic tretinoin requests only):
    - ❑ Actinic keratosis and member is greater than 29 years of age
    - ❑ 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 below

MEDICAL NECESSITY: Provide clinical evidence below that the preferred drug will not provide adequate benefit.

_____

_____

_____

_____

For all other topical acne drug requests (excluding formulary preferred adapalene or tretinoin products):

- ❑ 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®) **
    - ❑ 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)
    - ❑ benzoyl peroxide 5%/erythromycin 3% gel (generic Benzamycin)
    - ❑ clindamycin 1% topical
    - ❑ erythromycin 2% topical
    - ❑ tretinoin (generic Retin-A®) 0.025%, 0.05%, 0.1% cream or 0.01%, 0.025% gel **

(Continued on next page; signature page must be attached to this request form)

(Please ensure signature page is attached to form)

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.****

Member Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***Approved by Pharmacy and Therapeutics Committee**: 4/17/2014
REVISED/UPDATED: ~~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; (Reformatted) 6/19/2019; 11/11/2019; 6/24/~~2020; 6/30/2021; 4/25/2022; 6/15/2022; 6/16/2022;~~ **10/24/2022**