ACNE MEDICATION

(AVITA, AZELEX, DIFFERIN, FINACEA, RETIN-A, TAZORAC, TRETINOIN)

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES PHONE 800-979-UPMC (8762) FAX 412-454-7722

PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

Office Contact:	**Provider Specialty:**		
Provider First Name:	**Provider Last Name:**		
Provider Phone:	**Provider Fax:**	**Provider NPI #:**	
Patient Name:	**Member UPMC Health Plan ID #:**	**Patient DOB:**	**Patient Age:**

Drug Requested: ❑ Brand ❑ Generic	**Strength:**	**Frequency:**	**Qty Dispensed (tube size):**

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

❑ New medication ❑ Ongoing medication	**If ongoing, provide date started:**	**If medication is ongoing, Did the member Show improvement while on therapy**	❑ Yes ❑ No

Diagnosis:

Specify the area to be treated:

Specify the expected therapy duration:

History of formulary medications used to treat the above condition

Medication Trial/ Previous Therapies	Date of Therapy Start Date End Date	Strength	Frequency	List adverse reactions/side effects/ reason for discontinuing