US Family Health Plan

Prior Authorization Request Form for

Topical Acne and Rosacea Agents: Topical Retinoids and Combinations

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Prior authorization expires after one year.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #:		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Does the patient have a diagnosis of acne vulgaris?	☐ Yes Proceed to question 2	☐ No **STOP** **Coverage not approved**
2. Has the patient tried and failed at least three preferred topical generic acne products, including at least two different strengths of tretinoin? The preferred medications are adapalene (cream, gel, lotion), clindamycin (cream, gel, lotion, solution), clindamycin/benzoyl peroxide (combination) gel, tretinoin (cream, gel), and sulfacetamide sodium/sulfur lotion.	☐ Yes Sign and date below	☐ No Proceed to question 3
3. Has the patient experienced an adverse reaction or inadequate response to formulary preferred topical tretinoin agents that is not expected to occur with the non-preferred product?	☐ Yes Sign and date below	☐ No Proceed to question 4
4. Is the requested medication Epiduo or Epiduo Forte (generic adapalene/benzoyl peroxide)?	☐ Yes Proceed to question 6	☐ No Proceed to question 5
5. Is the requested medication Veltin or Ziana (generic tretinoin 0.025%/clindamycin 1.2%)?	☐ Yes Proceed to question 7	☐ No Proceed to question 6
6. Does the patient require combination topical adapalene/benzoyl peroxide?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
7. Does the patient require this particular strength of combination topical tretinoin 0.025%/clindamycin 1.2%?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[30 November 2022]