AmeriHealth Caritas Iowa

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Request for Prior Authorization

Isotretinoin (Oral)

Form applies to IA Health Link and ***hawk-i*** plans.

Please print – accuracy is important.

Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.

AmeriHealth Caritas Iowa member ID #:		Patient name:	
Patient address:			DOB:
Provider NPI:	Prescriber name:		Phone:
Prescriber address:			Fax:
Pharmacy name:			
Address:			Phone:
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.			
Pharmacy NPI:		Pharmacy fax:	NDC:

Prior authorization is required for oral isotretinoin therapy. Payment will be approved for preferred oral isotretinoin products for acne under the following conditions: 1. There are documented trials and therapy failures of systemic antibiotic therapy and topical tretinoin therapy. Documented trials and therapy failures of systemic antibiotic therapy and topical tretinoin therapy are not required for approval for treatment of acne conglobata. 2. Patients and providers must be registered in, and meet all requirements of, the iPLEDGE (www.ipledgeprogram.com) risk management program.Payment for non-preferred oral isotretinoin products will be authorized only for cases in which there is documentation of trial(s) and therapy failure with a preferred agent(s). Initial authorization will be granted for up to 20 weeks. A minimum of two months without therapy is required to consider subsequent authorizations.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult www.iowamedicaidpdl.com/pa_criteria.

Preferred: ☐ Amnesteem ☐ Claravis ☐ Myorisan ☐ Zenatane Non-Preferred: ☐ Absorica

Strength: Dosage Instructions: Quantity: Days Supply:

Diagnosis: Date of Initial Treatment:

*If PA extension, please specify exact date range of last drug-free interval: From: To:

Previous therapy (include drug name(s), strength and exact date ranges):

Please **submit documentation of trial failures with systemic (not topical) antibiotic & vitamin A derivative** such as topical tretinoin or Differin (adapalene); include drug names, strength, exact date ranges and failure reasons:

If female of child-bearing years, confirmed negative serum pregnancy test? ☐ Yes ☐ No

If yes, please list Prescriber: Date of pregnancy test:

Specify plan for contraception:

Reason for use of Non-Preferred drug requiring prior approval:

Other medical conditions to consider:

Possible drug interactions/conflicting drug therapies:

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Attach lab results and other documentation as necessary.

Please also fax the iPLEDGE consent form(s) signed by the patient. The iPLEDGE consent form(s) can be obtained online at www.ipledgeprogram.com.

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further attest that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.

Prescriber signature: (Must match prescriber listed above.)	Date of submission:

Important note: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.