



## Prior Authorization Request Form – Acne Medications

**Instructions:**

This form is to be used by participating providers to request coverage for acne medications requiring prior authorization. Please fill out this form COMPLETELY, including signature, and fax to MedMetrics Health Partners at 1-800-918-7542. Allow 24 hours to process request. Please call MedMetrics PA Line (available 24 hours a day) at 1-800-918-7550 for more urgent requests.

MedMetrics Health Partners – Prior Authorization Services      Phone: 1-800-918-7550  
 P. O. Box 2586, Worcester, MA 01606      Fax: 1-800-918-7542

An acne vulgaris and rosacea step therapy program has been developed to encourage the use of preferred, generic, first-line topical agents before more expensive brand-name second-line agents for the same indication.  
**First-line therapies include generic versions of: benzoyl peroxide, clindamycin 1%, erythromycin 2%, sulfacetamide, sulfacetamide 10%/sulfur 5%, tretinoin cream/gel and metronidazole 0.75% cream/gel/lotion.**

**Please PRINT and complete ALL of the following boxes:**

1. Member's FULL Name:	2. Member's NHP ID Number:	3. Member's DOB: (mm/dd/yy)
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4. Prescriber's FULL Name and Specialty:	5. Contact Person at Office:
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Prescriber's FAX and Telephone Number: Fax: (    )	Tel: (    )
Mailing Address:	

7. Requested Drug: <input type="checkbox"/> Aczone gel <input type="checkbox"/> adapalene 0.1% gel <input type="checkbox"/> adapalene 0.1% cream <input type="checkbox"/> Atralin gel <input type="checkbox"/> Azelex cream <input type="checkbox"/> Differin 0.3% gel <input type="checkbox"/> Differin 0.1% lotion <input type="checkbox"/> Finacea gel <input type="checkbox"/> Metrogel 1% ____ <input type="checkbox"/> Noritate 1% cream <input type="checkbox"/> Retin-A MICRO gel _____(strength) <input type="checkbox"/> Tazorac cream / gel <input type="checkbox"/> Other: _____	8. Diagnosis and Indication for Use: <hr/> <hr/> 9. Other Pertinent Information: <hr/> <hr/> <hr/>
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10. Has the member tried the following <b>within the past 6 months?</b>	
Drug Name (please check all that apply)	Response (please check all that apply)
<input type="checkbox"/> Generic benzoyl peroxide (BP)	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> Generic clindamycin 1%	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> Generic erythromycin 2%	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> Generic BP/sulfur	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> Generic BP/erythromycin	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> Generic sulfacetamide/sulfur	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> Generic tretinoin cream/gel	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> Generic metronidazole cream/gel/lotion	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy
<input type="checkbox"/> Other (please specify): _____	<input type="checkbox"/> side-effect <input type="checkbox"/> non-response <input type="checkbox"/> allergy

11. Prescriber comments:
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**Signature:**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

\_\_\_\_\_  
 Prescriber's signature

\_\_\_\_\_  
 Date