



REQUEST FOR PRIOR AUTHORIZATION ISOTRETINOIN

Absorica, Amnesteem, Clavaris, Myorisan, Zenatane

Prescribing Physician:	
Name (First, Last)	
Direct Phone #	
Fax #	
Physician specialty	

Patient:	
Name (First, Last)	
ID #	
Phone #	Client
Birth Date _ / _ / _	Sex M <input type="checkbox"/> F <input type="checkbox"/>

Name and title of person completing form (please print)			
Drug name:	Strength:	Length of Therapy:	Quantity Requested:
Has patient been on this drug and, if yes, for how long at this dosage?			
Patient's diagnosis requiring the use of this medication:			
Has the patient tried or failed the following therapies?			
<ul style="list-style-type: none"> Oral Antibiotics: Yes <input type="checkbox"/> No <input type="checkbox"/> Topical Retinoid Product: Yes <input type="checkbox"/> No <input type="checkbox"/> Topical Clindamycin or Erythromycin Product: Yes <input type="checkbox"/> No <input type="checkbox"/> 			
Please submit supporting documentation of use.			
List the therapies tried and failed by the patient, include the duration of therapy:			
Name of medication/therapy	Reason for failure	Duration of therapy	
When was the last pregnancy test performed?			
What are the 2 forms of contraception using simultaneously with isotretinoin treatment?			
Has the patient been enrolled in the iPledge Program? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Other Information:			

Physician's Signature _____ Date ____/____/____

Fax Request and Supporting Documentation to: SGRX @ 313-264-0985

For ScriptGuideRX use only)

Date faxed: ____/____/____
Date received: ____/____/____
Date completed: // ____

Decision (all authorizations are pending valid eligibility)
