PRIOR AUTHORIZATION REQUEST ISOTRETINOIN PRODUCTS

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

Patient:	
Name (First, Last)	
ID #	Sex (at birth): ❑ M ❑ F
Phone #	Client
Birth Date: ___/___/___	Age

Name and title of person completing form (please print):

1. Drug name:	2. Dose/Strength:	3. Frequency:	4. Length of Therapy:	5. Quantity Requested/month:
❑Isotretinoin ❑Claravis ❑Absorica ❑Myorisan ❑Amnesteem ❑Zenatane				

6. Patient's diagnosis & ICD code requiring the use of this medication: ______________________________

7. Please indicate the patient's most recent weight: ________________kg ________________ lbs

8. Is the patient currently on isotretinoin? ❑Yes ❑No

9. If currently on isotretinoin, please indicate on of the following:
❑ Cumulative dosage received (mg/kg): ______________
❑ Total number of pills dispensed to date: ______________

10. For NEW starts, Please indicated the target cumulative dosage for isotretinoin:
❑120mg/kg ❑150 mg/kg ❑other: __________

11. Has the patient tried or failed the following therapies below for at least 10 weeks? ❑Yes ❑No

Drug	Reason for failure	Dates
❑minocycline ❑doxycycline ❑erythromycin		From ___/___/___ To ___/___/___
❑Tretinoin topical ❑Azelaic Acid		From ___/___/___ To ___/___/___
❑Benzoyl peroxide		From ___/___/___ To ___/___/___
❑Previous isotretinoin cycle(s)		From ___/___/___ To ___/___/___

12. Has the patient been enrolled in the iPledge Program? ❑Yes ❑No

Other information:

Physician's Name (print): ______________________________ **Title:** _______________

Physician's Signature: ______________________________ **Date:** ___/___/___

Fax PA request form AND Supporting Documentation to: SGRX @ 313-264-0985