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 ☐ F ☐

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?

- Oral Antibiotics: Yes ❑ No ❑
- Topical Retinoid Product: Yes ❑ No ❑
- Topical Benzoyl Peroxide Product: Yes ❑ No ❑
- Topical Azelaic Acid Product: Yes ❑ No ❑

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 ❑ No ❑

Other Information:

Physician's Signature_____ **Date**____/___/_____

Office Visit Chart Notes are required for the review

Fax Request to: SGRX @ 313-264-0985

For ScriptGuideRX use only)

Date faxed: ___/___/___

Date received: ___/___/___

Date completed: ___/___/___

Decision (all authorizations are pending valid eligibility)