PRIOR AUTHORIZATION REQUEST
ISOTRETINOIN PRODUCTS

Prescribing Physician	
Name (First, Last)	
Physician Specialty	
Phone #	Fax #

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 ☐ Myorisan ☐ Claravis ☐ Amnesteem ☐ Absorica ☐ Zenatane				

6. Patient's diagnosis & ICD code requiring the use of this medication:	7. Please indicate the patient's most recent weight:	8. Is the patient currently on isotretinoin?
_____	_____ kg _____ lbs	☐ Yes ☐ No

9. If currently on isotretinoin, please indicate on of the following:	10. For NEW starts, please indicated the target cumulative dosage for isotretinoin:
☐ Cumulative dosage received (mg/kg): _____ ☐ Total number of pills dispensed to date: _____	☐ 120 mg/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
☐ Tretinion 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

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