

AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-305-671-0200.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Topical Acne Drugs (check applicable box below)

PREFERRED	
<input type="checkbox"/> adapalene (Differin [®]) cream/gel/solution *Requires prior authorization if used as treatment in a member \geq 29 years of age	<input type="checkbox"/> tretinoin (Retin [®] -A) cream 0.025%, 0.05%, 0.1%; gel 0.01%, 0.025% *Requires prior authorization if used as treatment in a member \geq 29 years of age
NON-PREFERRED	
<input type="checkbox"/> adapalene 0.3%/benzoyl peroxide 2.5% gel (Epiduo Forte [®])	<input type="checkbox"/> Altreno[®] (tretinoin) lotion 0.05%
<input type="checkbox"/> Aklief[®] (trifarotene) cream 0.005%	<input type="checkbox"/> Amzeeq[®] (minocycline) topical foam 4%
<input type="checkbox"/> Azelex[®] (azelaic acid) cream 20%	<input type="checkbox"/> clindamycin 1.2%/benzoyl peroxide 2.5% gel (Acanya [®])
<input type="checkbox"/> dapsone gel 5% (Aczone [®])	<input type="checkbox"/> erythromycin 3%/benzoyl 5% gel (Benzamycin [®])
<input type="checkbox"/> Retin[®]-A Micro (tretinoin microsphere) 0.06%, 0.08% gel	<input type="checkbox"/> tazarotene (Fabior [®]) foam 0.1%
<input type="checkbox"/> tretinoin gel 0.05% (Atralin [®])	<input type="checkbox"/> tretinoin microsphere gel 0.04%,0.1% (Retin [®] -A Micro)
<input type="checkbox"/> Winlevi[®] (clascoterone) cream 1%	

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

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DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

***NOTE: adapalene and all tretinoin based medications are restricted to NON-COSMETIC purposes. Requests for cosmetic indications will be denied as BENEFIT EXCLUSIONS**

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

For preferred adapalene or tretinoin product requests in member 29 years of age or older:

- Member must meet **ONE** of the following for generic adapalene or tretinoin requests:
 - Member has a diagnosis of acne vulgaris
 - Member has a diagnosis of rosacea
 - Member has a diagnosis of actinic keratosis (for generic tretinoin requests only)
 - Medication is being requested for a diagnosis not listed on prior authorization form and provider has submitted rationale for medical necessity of use with supporting clinical documentation

For all other topical acne drug requests:

- For all other topical acne drug requests, member must meet **BOTH** of the following:
 - Member has been diagnosed with acne vulgaris
 - Member must have documentation of at least a **30 day trial and failure** of **THREE (3)** of the following:
 - adapalene 0.1% cream/solution/gel or 0.3% gel (generic Differin[®]) *PA required ≥ 29 y.o.*
 - adapalene 0.1%/benzoyl peroxide 2.5% gel (generic Epiduo[®])
 - benzoyl peroxide OTC
 - benzoyl peroxide 1%, 1.2%/clindamycin 5% gel (generic BenzaClin[®] & Neuc[®]/Duac[®] gel)
 - clindamycin 1% topical
 - erythromycin 2% topical
 - tazarotene 0.1% cream
 - tretinoin (generic Retin-A[®]) 0.025%, 0.05%, 0.1% cream or 0.01%, 0.025% gel *PA required ≥ 29 y.o.*

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Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

*Approved by Pharmacy and Therapeutics Committee: 4/17/2014; 9/26/2024

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