Iowa Department of Human Services

Request for Prior Authorization
ISOTRETINOIN (ORAL)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone

Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.

Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for oral isotretinoin therapy. Payment will be considered for preferred oral isotretinoin products for moderate to severe acne under the following conditions: 1. There are documented trials and therapy failures of systemic antibiotic therapy and topical vitamin A derivative (tretinoin or adapalene) therapy. Documented trials and therapy failures of systemic antibiotic therapy and topical vitamin A derivative therapy are not required for approval for treatment of acne conglobata; and 2. Prescriber attests patient has enrolled in and meets all requirements of the iPLEDGE program.
Payment for non-preferred oral isotretinoin products will be authorized only for cases in which there is documentation of trial(s) and therapy failure with a preferred agent(s). Initial authorization will be granted for up to 24 weeks. A minimum of 8 weeks without therapy is required to consider subsequent authorizations.
The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred

☐ Amnesteem ☐ Claravis ☐ Myorisan ☐ Zenatane

Non-Preferred

☐ Absorica

Strength _____ **Dosage Instructions** _____ **Quantity** _____ **Days Supply** _____

Diagnosis:_____ Date of Initial Treatment: _____

*If PA extension, please specify exact date range of last drug-free interval: From: _____To:_____

Documentation of trial failures with systemic antibiotic & vitamin A derivative:
Systemic Antibiotic Drug Trial: Drug Name & Dose_____ Trial Dates:_____

Failure Reason_____

Vitamin A Derivative Drug Trial: Drug Name & Dose:_____ Trial Dates:_____

Failure Reason_____

Is patient enrolled in iPLEDGE program and meets all program requirements? ☐ No ☐ Yes

Reason for use of Non-Preferred drug requiring prior approval:_____

Other medical conditions to consider:_____

Possible drug interactions/conflicting drug therapies:_____

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*