HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM

ACNE VULGARIS AND ROSACEA

Aczone®, Aklief®, Epiduo® Forte, Fabior®, Mirvaso®, Rhofade®, Soolantra®, Tazorac®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142. Failure to submit clinical documentation to support this request will result in delay and/or denial of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Please note the following do not require prior authorization: adapalene, azelaic acid, topical antibiotics, topical benzoyl peroxide, topical metronidazole, topical retinoids

Product being requested: ☐ Aczone® (dapsone), ☐ Aklief® (trifarotene), ☐ Epiduo® Forte (adapalene/benzoyl peroxide), ☐ Fabior® (tazarotene), ☐ Mirvaso® (brimonidine), ☐ Rhofade® (oxymetazoline), ☐ Soolantra® (ivermectin), ☐ Tazorac® (tazarotene)

Dosing/Frequency:____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
ACZONE® or AKLIEF® or EPIDUO® FORTE or FABIOR® or TAZORAC®			
1. Is the member 12 years of age or older?	☐	☐	
2. Does the member have a diagnosis of inflammatory acne vulgaris?	☐	☐	**Please provide documentation**
3. Does documentation show that the member has tried and failed ALL of the following categories: • topical benzoyl peroxide • topical or oral antibiotic (e.g. clindamycin, sulfacetamide, erythromycin) • topical retinoid (e.g. adapalene, tretinoin, tazarotene) • Topical dapsone or tazarotene	☐	☐	**Please provide documentation**
MIRVASO® or RHOFADE® or SOOLANTA®			
1. Is the member 18 years of age or older?	☐	☐	
2. Does the member have a diagnosis of persistent erythema of rosacea?	☐	☐	**Please provide documentation**

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3. Does documentation show that the member has failed an adequate trial of a topical metronidazole agent?	☐	☐	**Please provide documentation**
4. Does documentation show that the member has failed an adequate trial of a topical azelaic acid?	☐	☐	**Please provide documentation**
5. Soolantra®is the preferred product. If Rhofade® or Mirvaso® is being requested, has Soolantra®been trialed and failed first?	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member's therapy been re-evaluated within the past 12 months?	☐	☐	
3. Does the member show a continued medical need for the therapy?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician's Signature:			

****Failure to submit clinical documentation to support this request will result in delay and/or denial of the request****

Policy PHARM- 001
Origination Date: 10/02/2018
Reviewed/Revised Date: 10/28/2020
Next Review Date: 10/28/2021
Current Effective Date: 11/01/2020

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