AmeriHealth Caritas New Hampshire

Oral Isotretinoin Medications

Prior Authorization Drug Approval Form

Date of medication request: (MM/DD/YYYY): ____ / ____ / _____

Patient information and medication requested	
Patient's name:	Medicaid number:
Date of birth:	Gender:
Drug name:	Strength:
Dosing directions:	Length of therapy:

Prescriber information		
Prescriber last name:		Prescriber first name:
Prescriber address:		Prescriber representative:
Specialty:	NPI number:	
Phone #:	Fax #:	

Clinical history
1. Please provide the diagnosis/condition this medication is being prescribed to treat: ☐ Yes ☐ No
2. Has the patient failed at least two conventional acne treatments? ☐ Yes ☐ No Please list treatment failures and dates:
3. Are patient and provider registered to the iPLEDGE® risk management program and are all requirements met, INCLUDING, if appropriate, a confirmed negative serum pregnancy test and a plan for contraception in place? ☐ Yes ☐ No
4. Has patient used oral isotretinoin therapy in the past? ☐ Yes ☐ No If yes, please provide medication names and dates:
Provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

Signature of prescriber:_____ Date: _____
(prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.