Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

pennsylvania
DEPARTMENT OF HUMAN SERVICES

ACNE AGENTS, TOPICAL PRIOR AUTHORIZATION FORM

- **Please submit all requested documentation with this form. Incomplete documentation may delay the processing of this request.**
- To review the prior authorization guidelines for Topical Acne Agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapters – **Acne Agents, Topical** (accessible at: http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm).

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐ New request ☐ Renewal request	Total # of pages: _______	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Name of medication requested: ______________________________

(For a complete list of preferred and non-preferred products, refer to the Preferred Drug List at https://papdl.com/preferred-drug-list.)

Strength/concentration:	Dose/directions:	Quantity per month:	Refills:

Formulation *(circle one)*: cream / emollient cream / ointment / lotion / gel / solution / spray / foam / other *(specify)*: ____________________

1. Does the beneficiary have a history of trial and failure, contraindication, or intolerance of the preferred topical acne agents? *Check all that apply. Submit documentation of topical acne agents tried and treatment outcomes.*

Antibiotic combinations
- ☐ Acanya gel pump
- ☐ clindamycin/benzoyl peroxide 1.2%-5% gel (generic Duac)
- ☐ Onexton gel pump

Benzoyl peroxide (BPO)
- ☐ Acne medication lotion (5% or 10%)
- ☐ benzoyl peroxide gel (2.5%, 5%, or 10%)
- ☐ benzoyl wash (5% or 10%)
- ☐ Panoxyl 10% acne cleansing bar or foaming wash
- ☐ Panoxyl-4 OTC acne creamy wash

Retinoids*
(*NOTE: the agents below only require prior authorization for beneficiaries 21 years of age and older)
- ☐ Azelex cream
- ☐ Differin 1% (Rx) cream, gel, or lotion
- ☐ Differin 3% gel pump
- ☐ Epiduo 0.1%-2.5% gel pump
- ☐ Finacea foam or gel
- ☐ Retin-A cream or gel

2. ***For beneficiaries 21 years of age or older***, does the recipient have a diagnosis of acne, rosacea, or plaque psoriasis? ☐ Yes ☐ No — *Submit documentation of beneficiary's diagnosis.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**:

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Form effective 7/23/18