Highmark Wholecare
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

I. Requirements for Prior Authorization of Acne Agents, Oral

1) Prescriptions That Require Prior Authorization

All prescriptions for Acne Agents, Oral must be prior authorized.

2) Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for an Acne Agent, Oral, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

i. Is being treated for a diagnosis that is indicated in the U.S. Food and Drug Administration (FDA)-approved package labeling OR a medically accepted indication; **AND**

ii. Is age-appropriate according to FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

iii. Is prescribed a dose and duration of therapy that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature; **AND**

iv. Is prescribed the Acne Agent, Oral by or in consultation with a dermatologist; **AND**

v. For an indication of acne, has a history of therapeutic failure of or a contraindication or an intolerance to **all** of the following:

1. An oral antibiotic recommended for the treatment of acne,
2. A topical antibiotic recommended for the treatment of acne,
3. A topical retinoid;

AND

vi. For a non-preferred Acne Agent, Oral, has a history of therapeutic failure of or a contraindication or an intolerance to the preferred Acne Agents, Oral. See the Preferred Drug List (PDL) for the list of preferred Acne Agents, Oral at: https://papdl.com/preferred-drug-list.

NOTE: If the beneficiary does not meet the clinical review guidelines above but, in the professional judgement of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

3) Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a Acne Agent, Oral. If the applicable guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the applicable guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

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ACNE AGENTS, ORAL PRIOR AUTHORIZATION FORM

☐New request ☐Renewal request	total # of pgs: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:
Dose/directions:	Quantity:
Duration of treatment:	Beneficiary's weight:
Diagnosis *(submit documentation)*:	Dx code (*required*):

Does the beneficiary have a diagnosis of severe acne?	☐Yes – *Submit documentation of diagnosis.* ☐No – *Submit medical literature supporting the use of the requested medication for the beneficiary's diagnosis.*
Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the following? Check all that apply. ☐topical antibiotics (e.g., clindamycin, erythromycin, sulfacetamide) ☐oral antibiotics (e.g., doxycycline, minocycline) ☐a topical retinoid (e.g., adapalene, tazarotene, tretinoin, trifarotene)	☐Yes ☐No *Submit all supporting documentation of other medications tried and treatment outcomes, including contraindications or intolerances.*
For a non-preferred Acne Agent, Oral: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred Acne Agents, Oral? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in each class.*	☐Yes ☐No *Submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances.*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO HIGHMARK WHOLECARE

Prescriber Signature:	**Date**: