Updated: 06/2019
PARP Approved: 06/2019

Prior Authorization Criteria

Topical Retinoid Agents

All requests for Topical Retinoid Agents require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Members 45 years of age and older will require prior authorization approval for a topical retinoid. Prior authorization criteria will not be applied to members younger than 45 years of age.

For all requests for topical retinoid agents all of the following criteria must be met:

- For all non-formulary requests the member must try up to two formulary agents first (if two agents are available for the member's diagnosis) or provide documentation of failure with up to two formulary agents if applicable
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- The member must not be using the requested agent for treatment of wrinkles, stretch marks, age spots, skin lightening, or other cosmetic purposes

Coverage may be provided with a diagnosis of plaque psoriasis (Tazorac (tazarotene) only)

Coverage may be provided with a diagnosis of acne

Coverage may be provided with a diagnosis of a cancerous or pre-cancerous skin condition

- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
    - Documentation the member is tolerating the medication and there is an ongoing medical need for the medication.
- **Reauthorization Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Gateway Health

Updated: 06/2019
PARP Approved: 06/2019

TOPICAL RETINOID PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

Medication:	Strength:
Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: ☐ Plaque psoriasis ☐ Acne ☐ Other: _____ ICD-10 Code: _____

CURRENT or PREVIOUS THERAPY

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

REAUTHORIZATION

Has the member experienced a significant improvement with treatment? ☐ Yes ☐ No
Please describe:

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date