Updated: 09/2024
DMMA Approved: 09/2024

Request for Prior Authorization for Oral Isotretinoin Agents
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Oral Isotretinoin Agents require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Oral Isotretinoin Agents Prior Authorization Criteria:

Oral Isotretinoin agents include Absorica, Amnesteem, Claravis, Myorisan, and Zenatane. New products with this classification will require the same documentation.

Coverage may be provided with a diagnosis of severe recalcitrant nodular acne (cystic acne) and the following criteria is met:

- Member is 12-20 years old
- Medication must be prescribed by or in consultation with a dermatologist
- Must provide documentation showing the member had tried and failed or had an intolerance or contraindication to all of the following first-line treatments:
    - A topical tretinoin
    - A topical antibiotic recommended for the treatment of acne with or without benzoyl peroxide
    - An oral antibiotic recommended for the treatment of acne
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- **Initial Duration of Approval:** 5 months
- **Reauthorization criteria**
    - Member must be have been off oral isotretinoin therapy for at least 2 months (8 weeks)
    - Persistent or recurring severe recalcitrant nodular acne is still occurring
    - Maximum of only one reauthorization will be issued.
- **Reauthorization Duration of Approval:** 5 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.

Drugs are authorized in generic form unless the branded product is on the preferred drug list or the prescriber has indicated in writing that the branded product is medically necessary. If only the branded product is on the preferred drug list, the generic form will be considered non-preferred and shall not require the prescriber to indicate in writing that the branded product is medically necessary.

HIGHMARK HEALTH OPTIONS

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ORAL ISOTRETINOIN AGENTS PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX: (855) 476-4158**
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: (844) 325-6251 Mon – Fri 8 am to 7 pm

PROVIDER INFORMATION

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

MEMBER INFORMATION

Member Name:	DOB:	
Member ID:	Member weight:	Height:

REQUESTED DRUG INFORMATION

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:	
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No		

Billing Information

This medication will be billed: ☐ at a pharmacy **OR** ☐ medically, 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: ☐ severe recalcitrant nodular acne (cystic acne) ☐ Other: _____

Has the member tried and failed or had an intolerance or contraindication to **all** of the following (please list below)? ☐ Yes ☐ No

- A topical tretinoin
- A topical antibiotic recommended for the treatment of acne with or without benzoyl peroxide
- An oral antibiotic recommended for the treatment of acne

CURRENT or PREVIOUS THERAPY

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

REAUTHORIZATION

Has the member been off of oral Isotretinoin therapy for at least 2 months (8 weeks)? ☐ Yes ☐ No
Is the persistent or recurring severe recalcitrant nodular acne still occurring? ☐ Yes ☐ No
If no, please explain:_____

Prescribing Provider Signature	Date