

Ticket #: _____ Request Date: _____ Request Time: _____

PHYSICIAN CERTIFICATION PRIOR AUTHORIZATION FORM

A request for the patient identified below has been made for the dispensing of **Isotretinoin®**. Based on recent clinical information, we require more information before this prescription can be paid by the patient's health benefit plan. Please fill out the following information and return to us as indicated below:

A. Member Information			
Patient Name:		Plan Name/Plan ID:	
Patient ID:	Patient Date of Birth:	Patient Contact Phone #:	
B. Physician Information			
Physician Name:		Physician Address:	
Physician DEA #:	Physician Phone #:	Physician Fax #:	
Drug Name and Strength:	Direction (SIG):	QTY and Days Supply:	NDC #:
C. Pharmacy Information			
Pharmacy Name:	NABP #:	Pharmacy Phone #:	Pharmacy Fax #:
D. Clinical Information (Please fill out the following information: circle all that apply)			
<p>1. Please select diagnosis below: (Must provide ICD-9/10 code and progress notes/medical record indicating diagnosis.)</p> <p><input type="checkbox"/> Acne (e.g., severe recalcitrant nodular acne, severe acne, cystic acne) ICD-9/10 Code(s): _____</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-9/10 Code(s): _____</p>			
<p>2. Has patient had a failure, contraindication or intolerance to any of the medications listed below? (check all that apply) YES NO</p> <p style="text-align: center;">Must have had an adequate trial of 6 or more weeks.</p> <p><input type="checkbox"/> A topical retinoid or retinoid-like agent [e.g. Retin-A/Retin-A Micro (tretinoin)]</p> <p><input type="checkbox"/> Benzoyl peroxide and an oral antibiotic [e.g. Ery-Tab (erythromycin), Minocine (minocycline)]</p> <p><input type="checkbox"/> Benzoyl peroxide and a topical antibiotic [e.g. Cleocin-T (clindamycin), erythromycin, BenzaClin (benzoyl peroxide/clindamycin), Benzamycin (benzoyl peroxide/erythromycin)]</p>			
<p>3. Is this medication being prescribed by a dermatologist? YES NO</p>			
Authorized Medical Signature:			
Telephone:		Date:	

When Completed Return To:

MC-Rx Clinical Division, 1267 Professional Parkway, Gainesville, GA 30507
1-866-965-Drug (3784) / Fax # 866-999-7736

**Please note that this form is to be completed by the prescribing physician. This form and its contents are permissible under HIPAA as the protected health information (PHI) contained in this letter is only being used for purposes related to the provision of treatment, payment and healthcare operations (TPO). HIPAA does restrict the communication of PHI with providers for TPO related purposes.

Prior authorization forms are reviewed at least annually and are available at www.MC-Rx.com. Medical Review Criteria are reviewed at least annually. Revised 5/2019