pennsylvania
DEPARTMENT OF HUMAN SERVICES

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

ACNE AGENTS, ORAL PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Acne Agents, Oral** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐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 DHS – PHARMACY DIVISION

Prescriber Signature:	**Date:**

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