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, TOPICAL PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Acne Agents, Topical** and **Quantity Limits/Daily Dose Limits** 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 pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
Facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Name of medication requested: _____

(For a complete list of preferred and non-preferred products, refer to the Preferred Drug List at https://papdl.com/preferred-drug-list.)

Formulation *(chose one)*:
☐ cleanser/wash ☐ gel
☐ cream ☐ lotion ☐ other: _____
☐ foam ☐ medicated pad/pledget

Strength/concentration:	Dose/directions:	Quantity per month:	Refills:

For a non-preferred Acne Agent, Topical: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred agents in this class approved or medically accepted for treatment of the beneficiary's condition? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.*	☐Yes – *Submit documentation.* ☐No
For a beneficiary 21 years of age or older, will the beneficiary be using the requested medication for a non-cosmetic indication? Indicate beneficiary's diagnosis: ☐acne ☐rosacea ☐plaque psoriasis ☐other: _____	☐Yes *Submit documentation of beneficiary's diagnosis.* ☐No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date: