Wellpoint

Dermatologics: Acne Products – Isotretinoin

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and return by fax to **844-493-9207** as soon as possible to expedite this request. Without this information, we may deny the request.

Apple Health Preferred Drug list: **https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx**

Date of request:	Reference #:	MAS:	
Patient:	Date of birth:	Wellpoint ID:	
Pharmacy name:	Pharmacy NPI:	Telephone number:	Fax number:
Prescriber:	Prescriber NPI:	Telephone number:	Fax number:
Medication and strength:	Directions for use:	Qty/Days supply:	

1. Is this request for a continuation of existing therapy? ☐ Yes ☐ No
   a. If yes, has the patient been experiencing recurrent or persistent moderate to severe acne or rosacea? ☐ Yes ☐ No
   b. If yes, is there documentation showing a positive clinical response? ☐ Yes ☐ No
2. Indicate the patient's diagnosis:

☐ Moderate to severe acne

☐ Moderate to severe rosacea

☐ Other. Specify:

3. Are the provider and patient enrolled in the iPLEDGE Risk Evaluation and Mitigation Strategy (REMS) program?

☐ Yes ☐ No

4. For non-preferred isotretinoin products: Has the patient tried and failed at least two (2) preferred isotretinoin products?

☐ Yes, specify the isotretinoin products and duration:

☐ Preferred isotretinoin product is not tolerated. Specify:

☐ Other. Specify:

5. Indicate patient's current weight? _____ kg Date taken: _____

For diagnosis of moderate to severe acne

6. Has the patient tried and failed any of the following in combination with topical benzoyl peroxide or a topical retinoid (in other words, tretinoin) with a duration of use of at least 1 month? (Check all that apply)

☐ Oral antibiotics (in other words, doxycycline, erythromycin, trimethoprim-sulfamethoxazole)

☐ Benzoyl peroxide

☐ Topical retinoid (in other words, tretinoin)

☐ For female patients: Oral contraceptives (excludes progestin-only products)

☐ For female patients: Spironolactone

☐ Other. Specify:

☐ None of the above

7. Has the patient previously been treated with a full course of isotretinoin for acne?

☐ Yes ☐ No

If yes, has it been at least 2 months since completion of the previous treatment?

☐ Yes ☐ No

For diagnosis of moderate to severe rosacea

Has the patient tried and failed any of the following in combination with oral antibiotics (in other words, doxycycline, clarithromycin, metronidazole) with a duration of use of at least 1 month? (Check all that apply)

☐ Topical ivermectin

☐ Topical antibiotics (in other words, metronidazole)

☐ Other. Specify:

☐ None of the above

Required with this request:

• Chart notes • Labs • Diagnostic tests results		
Prescriber signature	Prescriber specialty	Date