



Dermatologics: Acne Products – Isotretinoin

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request.

Please FAX responses to: (800) 869-7791. Phone: (855) 322-4082, Options 0,1,2,3. Apple Health Preferred Drug list: <https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx>

Date of request			
Patient	Date of birth	Molina 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 (i.e. tretinoin) with a duration of use of at least 1 month? (Check all that apply)
- Oral antibiotics (i.e. doxycycline, erythromycin, trimethoprim-sulfamethoxazole)
 - Benzoyl peroxide
 - Topical retinoid (i.e. 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

8. Has the patient tried and failed any of the following in combination with oral antibiotics (i.e. doxycycline, clarithromycin, metronidazole) with a duration of use of at least 1 month? (Check all that apply)
- Topical ivermectin
 - Topical antibiotics (i.e. metronidazole)
 - Other. Specify:
 - None of the above

REQUIRED WITH THIS REQUEST:

- Chart notes
- Labs
- Diagnostic tests results

Prescriber signature	Prescriber specialty	Date
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