EXPRESS SCRIPTS®

Prior Authorization Form
Tazorac

This form is based on Express Scripts standard criteria and may not be applicable to all patients; certain plans and situations may require additional information beyond what is specifically requested.
Additional forms available: www.express-scripts.com/pa

Fax completed form to **1-877-329-3760**
If this an **URGENT** request, please call 1-800-753-2851

Patient Information

Patient First Name: _____

Patient Last Name: _____

Patient ID#: _____

Patient DOB: _____

Patient Phone #: _____

Prescriber Information

Prescriber Name: _____

Prescriber DEA/NPI **(required)**: _____

Prescriber Phone #: _____

Prescriber Fax #: _____

Prescriber Address: _____

State: _____ Zip Code: _____

Primary Diagnosis: _____ ICD Code: _____

Please indicate which drug and strength is being requested:

- ☐ Tazorac 0.05% Topical Cream
- ☐ Tazorac 0.05% Topical Gel
- ☐ Tazorac 0.1% Topical Cream
- ☐ Tazorac 0.1% Topical Gel

Directions for use (i.e. QD, BID, PRN & Qty): _____

1. What is the indication or diagnosis?

- ☐ Acne Vulgaris
- ☐ Actinic keratosis
- ☐ Basal cell carcinoma
- ☐ Congenital ichthyoses (X-linked recessive ichthyosis, non-erythrodermic autosomal recessive lamellar ichthyosis, autosomal dominant ichthyosis vulgaris)
- ☐ Keratosis pilaris (atrophicans)
- ☐ Mycosis fungoides lesions/cutaneous T-cell lymphomas
- ☐ Oral lichen planus
- ☐ Plaque psoriasis (psoriasis vulgaris)
- ☐ Psoriasis of fingernails or toenails
- ☐ Acne rosacea
- ☐ Folliculitis
- ☐ Warts
- ☐ Dermatitis or eczema
- ☐ Comedonal acne or cystic acne
- ☐ Skin neoplasms
- ☐ Conditions not listed above (please document): _____

For conditions not listed above, has the patient tried one other therapy for the current condition?

☐ Yes (please indicate) ☐ No

_____

2. For the diagnosis of Acne Vulgaris only, has the patient had a trial with at least one other topical retinoid product (e.g., tretinoin cream/gel/solution/microgel [Avita, Retin-A, Retin-A Micro, generics], Differin, [adapalene])?

☐ Yes (please indicate) ☐ No ☐ Not Applicable

_____

_____

Are there any other comments, diagnoses, symptoms, and/or any other information the physician feels is important to this review?

_____

_____

_____

_____

_____

_____

_____

Prescriber Signature: _____Date: _____

Office Contact Name: _____ Phone Number: _____

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.