

**Iowa Department of Human Services**  
**REQUEST FOR PRIOR AUTHORIZATION**  
**ANTI-ACNE PRODUCTS - TOPICAL**  
*This form is used for both preferred and non-preferred agents.*  
**(PLEASE PRINT -ACCURACY IS IMPORTANT)**

IA Medicaid  
 Member ID #: \_\_\_\_\_ Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Patient Address: \_\_\_\_\_  
 Provider NPI: \_\_\_\_\_ Prescriber Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Prescriber Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Pharmacy Name: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
**Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.**  
 Pharmacy  
 NPI: \_\_\_\_\_ Pharmacy Fax: \_\_\_\_\_ NDC : \_\_\_\_\_

**Prior authorization is required for all prescription topical acne products for the treatment of mild to moderate acne vulgaris. An initial treatment failure of an over-the-counter benzoyl peroxide product is required prior to the initiation of a prescription product. Note: Benzoyl Peroxide (OTC) does not require a prior authorization and is a covered OTC payable product by Iowa Medicaid.\*Requests for non-preferred combination products may only be considered after documented separate trials and therapy failures with the individual ingredients.**

**Preferred**

- Akne-Mycin  Metrogel 1%
- Azelex  Metro lotion
- BenzamycinPak  Plexion
- Clindamycin  Rosac
- Differin  Triaz Cleanser
- Erythromycin  Triaz Pads
- Metronidazole Cream

**Non-Preferred**

- Aczone
- Benzac AC
- Benzac AC Wash
- Benzacilin\*
- Benzamycin\*
- Brevoxyl
- Cleocin T
- Clindagel
- Clindamycin/BPO\*
- Epiduo\*
- Erythromycin/BPO\*
- Finacea
- Klaron
- Metrocream
- Noritate
- Rosanil Cleanser
- Sodium Sulfa/Sulf
- Sulfacet-R
- Triaz Cloths
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- Other (specify) \_\_\_\_\_

Strength	Form (wash, gel, etc.)	Usage Instructions	Quantity	Days Supply
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**Diagnosis:** \_\_\_\_\_

Benzoyl peroxide trial: Drug Name \_\_\_\_\_ Strength \_\_\_\_\_ Instructions \_\_\_\_\_

Trial date from: \_\_\_\_\_ Trial date to: \_\_\_\_\_

Medical or contraindication reason to override trial requirements: \_\_\_\_\_

Reason for use of Non-Preferred drug requiring prior approval: \_\_\_\_\_

Pertinent Lab data: \_\_\_\_\_

Other relevant information: \_\_\_\_\_

Possible drug interactions/conflicting drug therapies: \_\_\_\_\_

**Attach lab results and other documentation as necessary.**

Prescriber Signature: \_\_\_\_\_ Date of Submission: \_\_\_\_\_

**\*MUST MATCH PRESCRIBER LISTED ABOVE**

**IMPORTANT NOTE:** In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.