

Topical Retinoids/Retinoid-Like Agents

Prior Authorization Request (Physician to Complete)



Visit www.wellmark.com for the Wellmark Drug List for current medication tier levels and updated PA Forms

Facsimile Transmittal Sheet

Date: ____/____/____

To: Wellmark Pharmacy Services

From (Prescriber's Name): _____

Fax Number: (866) 884-4345

Prescriber's DEA Number: _____

Phone Number: (800) 600-8065

Prescriber's Phone Number: _____

Prescriber's Specialty: _____

Prescriber's Fax Number: _____

Prescriber's Office Address: _____
Street Suite # City State Zip

Patient Name: _____

Patient ID: _____ Patient DOB: ____/____/____

Please answer the following questions and fax this form back to (866) 884-4345. All fields are REQUIRED.

1. Please provide the diagnosis this therapy has been prescribed for: _____

2. Does the patient's diagnosis include a pre-malignant or malignant skin condition? Yes No

Note: No coverage for cosmetic purposes

3. Select one:

- tretinoin (lowest copay)**
- Atralin (tretinoin)
- Avita (tretinoin)
- Differin (adapalene)
- Epiduo (adapalene/benzoyl peroxide)
- Renova (tretinoin)
- Retin-A (tretinoin)
- Retin-A Micro (tretinoin)
- Tretin-X (tretinoin)
- Veltin (clindamycin and tretinoin)
- Ziana (clindamycin and tretinoin)

4. Drug Strength: _____ mg Quantity/30 days: _____ units

Directions: _____

Printed Name

Signature

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