Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Topical Acne Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 1 year; Continuation- 1 year

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Topical Acne.** Please complete and fax this form back to Kaiser Permanente within 24 hours [fax: 1-866-331-2104]. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless this form is complete. The KP-MAS Formulary can be found at:** **http://pithelp.appl.kp.org/MAS/formulary.html**

1 – Patient Information

Patient Name: ______________________ Kaiser Medical ID#: ______________ Date of Birth: ___________

2 – Provider Information

Provider Name: ______________________ Provider NPI: ______________________

Provider Address: ____

Provider Phone #: ____________________Provider Fax #: ______________________

Please check the boxes that apply:

☐Initial Request ☐ Continuation of Therapy Request

Provider Signature____

3 – Pharmacy Information

Pharmacy Name: ______________________ Pharmacy NPI: ______________________

Pharmacy Phone #______________________ Pharmacy Fax #: ______________________

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: ____
Sig: ____

Drug 2: Name/Strength/Formulation: ____
Sig: ____

5 -Clinical Criteria

Patient > 18 years old with Diagnosis of Acne?

□ No □ Yes

6-Medical Information

If requesting a non-preferred medication, has the patient failed an adequate trial of preferred product?

□ No □ Yes

If yes, list below and provide clinical evidence that the preferred agent(s) will not provide adequate benefit:

____

____

Drug 1	Strength	Length of Trial	Reason for discontinuation of the drug
Drug 2	Strength	Length of Trial	Reason for discontinuation of the drug

7 – Provider Sign-Off

Additional Information – Please provide any additional information that should be taken into consideration.

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I certify that the information provided is accurate. Supporting documentation is available for State audits.

Provider Signature:	Date:

Please Note: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is private and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of any action in reliance on the contents of this telecopied information is strictly prohibited. Please notify sender if document was not intended for receipt by your facility