HEALTH PLAN SELECT

Health Plan Select, 295 W. Clayton Street, Athens, GA, 30601

PREFERRED DRUG PLAN
PRE-AUTHORIZATION FORM

IN-OFFICE USE ONLY
HPS RESPONSE
DATE APPROVED: ________________
DATE NOT APPROVED: ___________

ORDERING PROVIDER NAME: ____

Date:______________________________

PROVIDER CONTACT NAME/ PHONE & FAX NUMBERS: ______________________________

PATIENT NAME: ___________________________________MEMBER NUMBER: ________________

____ Accutane (Generic: isotretinoin) All Oral

1. Does the patient have severe, nodular, cystic acne which will not respond to any less dangerous treatment than Accutane as initial treatment? YES NO

2. If number 1 does not apply, *ALL* of the following criteria must be met. (Please circle.)

YES Does the patient have a diagnosis of severe (recalcitrant) nodular acne?
YES Has the patient tried and failed systemic antibiotics?
YES Has the patient tried and failed any of the following treatments in addition to Systemic antibiotics?
  a) Topical antibiotics (for example: topical clindamycin or topical erythromycin)
  b) Benzoyl peroxide products.
  c) Topical retinoids (for example: Retin-A, Avita, and Altinac)

3. If either number 1 or number 2 applies *ALL* of the following criteria must be met. (Please circle.)

YES Has the physician completed the documentation necessary for the System to Manage Accutane Related Teratogenicity (S.M.A.R.T.)?
YES Is the physician aware that Accutane may cause depression, psychosis, or suicide?
YES Has an Accutane Informed Consent Form been signed by the patient or by his or her parent or guardian?

Strength: ________________ **Dosage form:** ________________

****Prior Authorization for this drug is granted on an initial basis for 5 months****

Fax form to Utilization Management: (706) 208-0024 or 800-327-2004
A response will be returned within one business day.
Contact: Quality/Utilization Management Department
(706) 549-0549 or 800-293-6260, extension 4823

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