GHP Family Pharmacy Customer Service
100 N. Academy Ave.
Danville, PA 17822
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Geisinger

ACNE AGENTS, ORAL PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Acne Agents, Oral** are available on Geisinger Health Plan's website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

☐New request ☐Renewal request	total # of pgs: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Drug requested:	Strength:
Dose/directions:	Quantity:
Duration of treatment:	Beneficiary's weight:
Diagnosis *(submit documentation)*:	Dx code (*required*):

Does the beneficiary have a diagnosis of severe acne?	☐Yes – *Submit documentation of diagnosis.* ☐No – *Submit medical literature supporting the use of the requested medication for the beneficiary's diagnosis.*
Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the following? Check all that apply. ☐topical antibiotics (e.g., clindamycin, erythromycin, sulfacetamide) ☐oral antibiotics (e.g., doxycycline, minocycline) ☐a topical retinoid (e.g., adapalene, tazarotene, tretinoin, trifarotene)	☐Yes ☐No *Submit all supporting documentation of other medications tried and treatment outcomes, including contraindications or intolerances.*
For a non-preferred Acne Agent, Oral: Does the beneficiary have a history of trial and failure of or contraindication or intolerance to the preferred Acne Agents, Oral? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in each class.*	☐Yes ☐No *Submit all supporting documentation of preferred agents tried and treatment outcomes, including contraindications or intolerances.*

Please submit to PromptPA https://ghp.promptpa.com OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature:	**Date**: