



Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

Prior Authorization Form

Arkansas Blue Cross and Blue Shield (Medicare) Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS) Tretinoin Products (Medicare Prior Authorization)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Tretinoin Products (Medicare Prior Authorization).

Drug Name (select from list of drugs shown)

Atralin Gel 0.05% (tretinoin gel) Avita (tretinoin) Retin-A Micro (tretinoin)
Tretinoin

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each applicable question.

- Does the patient have the diagnosis of Keratosis Follicularis (Darier's disease, Darier-White disease)? Y N
 [If the answer to this question is yes, no further questions are required.]
- Does the patient have the diagnosis of acne vulgaris? Y N

Comments: _____

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date