Tazorac® (tazarotene) Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.

This form may be faxed to 844-403-1029.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP:	Office Street Address:		
Phone:			City:	State:	ZIP:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
	Directions for Use:	

Clinical Information (required)	
1. Does the patient have a diagnosis of acne vulgaris?	❑ Yes ❑ No
2. Has the patient tried and failed a generic topical tretinoin product?	❑ Yes ❑ No
3. Does the prescriber deem that a generic topical tretinoin product would be inappropriate for the patient?	❑ Yes ❑ No
4. Is the patient a female and has child-bearing capabilities (e.g., no hysterectomy, has achieved menses and has not reached menopause)?	❑ Yes ❑ No
5. Has the prescriber discussed with the patient the potential risks of fetal harm and the need to avoid pregnancy or use birth control while using tazarotene products?	❑ Yes ❑ No
6. Does the patient have a diagnosis of plaque psoriasis?	❑ Yes ❑ No
7. Is the affected area(s) less than 20 percent of the patient's total body surface area?	❑ Yes ❑ No
8. Has the patient tried at least two topical corticosteroids (e.g., triamcinolone, mometasone, fluocinonide, clobetasol)?	❑ Yes ❑ No
9. Does the patient have a contraindication to topical corticosteroids?	❑ Yes ❑ No
10. Is the patient a female and has child-bearing capabilities (e.g., no hysterectomy, has achieved menses and has not reached menopause)?	❑ Yes ❑ No
11. Has the prescriber discussed with the patient the potential risks of fetal harm and the need to avoid pregnancy or use birth control while using tazarotene products?	❑ Yes ❑ No
12. Does the patient have a diagnosis of cancer? If yes, please indicate the cancer diagnosis:_____	❑ Yes ❑ No

Information on this form is accurate as of this date.

Prescriber's Signature:	**Date:**

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: **This request may be denied unless all required information is received.**
For more information about the prior authorization process, please contact us at 855-811-2218.
Monday – Friday: 8 a.m. to 1 a.m. Eastern, and Saturday: 9 a.m. to 6 p.m. Eastern