

Health New England Medication Request Form (MRF)

Atralin® (tretinoin), Differin ® (adapalene) Retin-A® (tretinoin), Tretin-X® (tretinoin), Tazorac ® (tazarotene), and tretinoin*.

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Prior Authorization

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of (adapalene, tretinoin and tazarotene). Please complete this form and fax to MedMetrics Health Partners at **(800) 550-9246**. If you have any questions regarding this process, please contact MedMetrics clinical call center at **(866) 209-1057**.

* applies to ALL tretinoin branded products unless coverage is excluded.

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Information (all required)	Physician Information (all required)
Patient Name:	Physician Name:
	Specialty:
	NPI #:
Patient HNE ID#:	HNE Provider #:
Patient Date of Birth:	DEA #:
Allergies:	Area Code and Telephone #: () -
Diagnosis:	Area Code and Fax # (required): () -

Drug Information

Requested Drug: <input type="checkbox"/> tretinoin <input type="checkbox"/> tazarotene <input type="checkbox"/> adapalene		
Dose, directions and length of treatment (please be specific):	Quantity:	Refills:
Physician signature:	Date:	
Indication:		
<input type="checkbox"/> Acne vulgaris <input type="checkbox"/> Psoriasis (tazarotene is FDA approved for this indication) <input type="checkbox"/> Other (please describe): _____		
Documentation of Medical Necessity (check all that apply):		
<input type="checkbox"/> Psoriasis covers _____ percent of body <input type="checkbox"/> Patient has failed a trial of a topical generic tretinoin product. <input type="checkbox"/> Patient had a negative pregnancy test (required) and is currently using birth control or is aware of the risks associated with pregnancy (if female). <input type="checkbox"/> Patient does not have eczema or other chronic skin conditions effecting area to be treated. <input type="checkbox"/> Medication is not being used for the treatment of hyperpigmentation caused by folliculitis, acne or eczema or mottled hyperpigmentation. <input type="checkbox"/> Other pertinent history: _____		