

APPLIES TO COMMERCIAL AND MEDICAID  
**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 Health New England Pharmacy Services Department at **(413) 233-2777**. If you have any questions regarding this process, please contact Health New England Member Services Department at **(800) 310-2835**.

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

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

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

**Drug Information**

<b>Requested Drug:</b> <input type="checkbox"/> tretinoin <input type="checkbox"/> tazarotene <input type="checkbox"/> adapalene		
<b>Dose, directions and length of treatment (please be specific):</b>	<b>Quantity:</b>	<b>Refills:</b>

<b>Physician signature:</b>	<b>Date:</b>
-----------------------------	--------------

**Indication:**

- Acne vulgaris
- Psoriasis (tazarotene is FDA approved for this indication)
- Other (please describe): \_\_\_\_\_

**Documentation of Medical Necessity (check all that apply):**

- Psoriasis covers \_\_\_\_\_ percent of body
- Patient has failed a trial of a topical generic tretinoin product.
- Patient had a negative pregnancy test (required) and is currently using birth control or is aware of the risks associated with pregnancy (if female).
- Patient does not have eczema or other chronic skin conditions effecting area to be treated.
- Medication is not being used for the treatment of hyperpigmentation caused by folliculitis, acne or eczema or mottled hyperpigmentation.
- Other pertinent history: \_\_\_\_\_