

**Prior Authorization Form**  
**Date Criteria: 06/01/2009**  
**CAREFIRST BLUECROSS BLUE SHIELD**  
**Topical Retinoids**

**Complete information, sign and date. Fax completed forms to Argus at 1-800-315-4025.**

**This fax machine is located in a secure location as required by HIPAA regulations.**

**When conditions are met, we will authorize coverage of Tretinoin Products.**

**Please contact Argus at 1-800-314-2872 with questions regarding the prior authorization process.**

**Drug Name:** \_\_\_\_\_

**Patient:**

**Patient Name:** \_\_\_\_\_

**Patient ID:** \_\_\_\_\_

**Patient's Group Number:** \_\_\_\_\_

**Patient's Date of Birth:** \_\_\_\_\_

**Prescribing Physician:**

**Physician Name:** \_\_\_\_\_

**Physician Phone:** \_\_\_\_\_

**Physician Fax:** \_\_\_\_\_

**Prescriber ID:** \_\_\_\_\_

**Physician Address:** \_\_\_\_\_

**Physician City, State, Zip:** \_\_\_\_\_

1. Does the patient have a diagnosis of acne vulgaris?

Y  N

2. Does the patient have a diagnosis of psoriasis? (Tazorac only)

Y  N

3. Please provide diagnosis if not listed above.

\_\_\_\_\_

Comments:

\_\_\_\_\_

*Information given on this form is accurate as of this date.*

\_\_\_\_\_

**Prescriber or Authorized Signature**

**Date**