

## Aczone Gel PA FORM



**Fax Completed Form to:**  
**866-254-0761**  
**For questions regarding this**  
**Prior authorization, call**  
**866-773-0695**

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a new prescription for Aczone gel must try other topical acne agents as first line therapy.

**Part I: TO BE COMPLETED BY PRESCRIBER**

Recipient Name		Recipient Date of Birth		Recipient Medicaid ID Number	
Prescriber Name					
Prescriber Medicaid Provider Number			Telephone Number		Fax Number
Address		City		State	Zip Code
<b>Requested Drug and Dosage:</b>  <input type="checkbox"/> ACZONE GEL			<b>Diagnosis for this request:</b>		
<b>Qualifications for coverage:</b>					
<input type="checkbox"/> Failed acne therapy Name of medication failed:  _____	Start Date	End Date		Dose	Frequency
<input type="checkbox"/> <i>I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.</i>					
Prescriber Signature				Date	

**Part II: TO BE COMPLETED BY PHARMACY**

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:		
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #		

**Part III: FOR OFFICIAL USE ONLY**

Date Received			Initials:		
Approved - Effective dates of PA: From:     /     /     To:     /     /			Approved by:		
Denied: (Reasons)					