

Neighborhood Health Plan of RI
Prior Authorization for
Retin-A (tretinoin)
(Retin-A Micro & Retin-A 0.05% Liquid: not covered)
Customer Service (401) 459-6020
Fax Number 866-423-0945

If approval criteria are met Neighborhood Health Plan of RI will authorize coverage of **Retin-A (tretinoin)**. Failure to fill out this form will result in a rejection of this medication at the pharmacy. Thank you for your assistance.

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Date of Request ____/____/____

Patient Name: _____ NHPRI ID#: _____

DOB: _____

Provider Name: _____ Provider Phone number: _____

Provider Fax number: _____

Name of Contact Person at Provider's office _____

Circle One: 0.025% Cream, 0.05% Cream, 0.1% Cream, 0.025% Gel, 0.01% Gel
(Retin-A Micro & Retin-A 0.05% Liquid are not covered)

INDICATIONS FOR USE (prior authorization only required for ages =>40) YES NO

<i>*Requests for Retin-A for cosmetic purposes (melasma, wrinkles, etc.) will be denied*</i>	<input type="checkbox"/>	<input type="checkbox"/>
1. Patient is diagnosed with acne vulgaris.	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Medication is being used for as treatment of pre-cancerous or cancerous skin lesion (e.g. actinic keratosis)	<input type="checkbox"/>	<input type="checkbox"/>

3. Other indications, please state: _____

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

 Prescriber's signature and NPI

 Date