# Neighborhood Health Plan of Rhode Island
# 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 Rhode Island 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:______________________________Neighborhood 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 |
|---|---|---|
| **Requests for Retin-A for cosmetic purposes (**melasma, wrinkles**, etc.) will be denied** | | |
| 1. Patient is diagnosed with acne vulgaris. | ☒ | ☐ |
| 2. Medication is being used for as treatment of pre-cancerous or cancerous skin lesion (e.g. actinic keratosis) | ☐ | ☐ |

3. Other indications, please state: ________________________________________________

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

______________________________ ______________________
Prescriber's signature and NPI Date

NHPRI PA Form
Current as of 2/22/06
Updated 5-2-06, Dec 2009