



Date of Request: _____

Sterling Retiree Rx Prior Authorization Form

ACNE MEDICATIONS (Topical)

Indications for Coverage

Acne vulgaris, keratosis follicularis (Darier disease, Darier-White disease)

Exclusion Criteria

Cosmetic use

Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physicians Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			

Requested Drug

	Reason for Request	
Condition/Diagnosis Related		

Clinical Drug/Lab History Pertinent to Request

Labs: Baseline/Ongoing	Strength/Dosage		
Formulary Alternative(s) Attempted?	Yes:		No:
Please List Alternative Formulary Drugs			

Comments	
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Physicians Signature: _____

Fax Form to 1-877-847-9904