



**Tazarotene (Tazorac®)
PRIOR REVIEW/CERTIFICATION FAXBACK FORM**

**INCOMPLETE FORMS MAY DELAY PROCESSING
ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT BCBSNC PROVIDER ID# BELOW**

PRESCRIBER INFORMATION		PATIENT INFORMATION
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH
PRACTICE ADDRESS	CITY	STATE ZIP

Dx Code: _____

Indicate condition for which tazarotene is being prescribed and answer the associated questions, if any:

Treatment of psoriasis

Treatment of acne vulgaris

Tazarotene (Tazorac) requires physician written certification. Coverage will be limited to the preferred generic drug unless written certification is provided by the physician stating that the patient meets the specific criteria listed in the signature box.

1) Has the patient failed treatment with generic tretinoin? Yes No

2) Has the patient experienced intolerable side effects with generic tretinoin? Yes No

Treatment of another condition (please describe): _____

Please certify the following by signing and dating below:

I certify that the above-referenced patient has previously used the preferred generic drug, as indicated above, and such drug was detrimental to the patient's health or was ineffective in treating the patient's condition and, in my opinion, is likely to be detrimental to the patient's health or ineffective in treating the condition again. I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): _____ Date: _____

For BCBSNC members, fax form to 1-800-795-9403