



**Topical Tretinoin
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: _____

1) For which of the following conditions is the requested tretinoin product being prescribed

Treatment of acne vulgaris

Treatment of actinic keratosis

Treatment of ichthyoses

Treatment of another condition (please describe): _____

2) Indicate the drug product being requested and answer the associated questions, if any:

Generic tretinoin or tretinoin combinations

Brand-name Tretinoin or Tretinoin combinations

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

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

Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service. 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