



Phone: 800-842-2015 Fax: 877-837-5922

PATIENT DATA	Last Name	First Name	Policy Number	Date of Birth	Age
REQUESTING PHYSICIAN DATA	Last Name	First Name	Contact Name	Fax Number ()	
BCBSLA Provider Number	Area of Practice/Specialty	Name of Place of Treatment	Treatment Center Provider #	Phone Number ()	
BILLING DATA	Diagnosis Code(s) (ICD-9): 1) 2)		CPT-4/HCPCS Code	Other Codes	

DRUG INFORMATION

<input type="checkbox"/> AVITA®	<input type="checkbox"/> VELTIN®
<input type="checkbox"/> RETIN A®	<input type="checkbox"/> ZIANA®
<input type="checkbox"/> RETIN-A MICRO®	<input type="checkbox"/> tretinoin
<input type="checkbox"/> TRETIN X®	

INDICATION / DIAGNOSIS

<input type="checkbox"/> Acne rosacea	<input type="checkbox"/> Ichthyosis	<input type="checkbox"/> Premature aging and treatment of photo-aged or photo-damaged skin
<input type="checkbox"/> Acne vulgaris	<input type="checkbox"/> Keloids	<input type="checkbox"/> Pseudofolliculitis
<input type="checkbox"/> Actinic keratosis	<input type="checkbox"/> Keratosis follicularis (Darier's disease)	<input type="checkbox"/> Psoriasis
<input type="checkbox"/> Alopecia areata	<input type="checkbox"/> Keratosis pilaris	<input type="checkbox"/> Sebaceous cyst
<input type="checkbox"/> Confluent and reticulated papillomatosis	<input type="checkbox"/> Lichen planus	<input type="checkbox"/> Sebaceous hyperplasia
<input type="checkbox"/> Cystic acne	<input type="checkbox"/> Lichen sclerosus	<input type="checkbox"/> Seborrheic keratosis
<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Melasma (common in pregnancy) or cholasma	<input type="checkbox"/> Skin cancer
<input type="checkbox"/> Diabetic foot ulcers	<input type="checkbox"/> Milia	<input type="checkbox"/> Solar kelastosis
<input type="checkbox"/> Eczema	<input type="checkbox"/> Molluscum contagiosum	<input type="checkbox"/> Stretch marks, scarring, androgenic alopecia
<input type="checkbox"/> Folliculitis	<input type="checkbox"/> Mucositis	<input type="checkbox"/> Warts
<input type="checkbox"/> Geographic tongue	<input type="checkbox"/> Oral leukoplakia	<input type="checkbox"/> Other Indication: _____
<input type="checkbox"/> Hyperpigmentation caused by folliculitis, acne, and eczema		

OTHER CLINICAL INFORMATION (Check ALL that apply)

Yes No Has the patient tried at least one other therapy for the current diagnosis? Specify: _____

List any other additional clinical info if applicable: _____

PHYSICIAN SIGNATURE

DATE

Prescribing Physician _____

Note: On behalf of Blue Cross and Blue Shield of Louisiana, prior authorizations are administered by Express Scripts, Inc., an independent pharmacy benefit management company. Please note that the authorization is not a guarantee of payment. Payment is subject to the member's eligibility, benefits, and pre-existing condition limitations at the time the services are provided. We recommend you contact BCBSLA at 800-922-8866 to verify benefits. The submitting provider certifies that the information contained herein is true, accurate, and complete and the requested services are medically necessary to the health of the patient.

Incomplete forms will not be processed