

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM
RETIN-A (tretinoin) for Kaposi's Sarcoma

Patient name: _____ Medicaid ID #: _____
Prescriber Name: _____ Prescriber NPI#: _____ Contact person: _____
Prescriber Phone#: _____ Extension/Option: _____ Fax#: _____
Pharmacy: _____ Pharmacy Phone#: _____ Pharmacy Fax #: _____
Requested Medication: _____ Strength: _____ Frequency/Day: _____

All information to be legible, complete and correct or form will be returned

**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN
LETTER OF MEDICAL NECESSITY TO 855-828-4992**

CRITERIA:

- Diagnosis of cutaneous lesions caused by Kaposi's Sarcoma
 - Pre-panretin use
 - List number of primary KS lesions
 - Indicate if lesions are flat or raised
 - Estimated total square centimeters

INFORMATION:

- Not to be used when systemic anti-Kaposi's Sarcoma therapy is required.
- For adult acne diagnoses, use the Adult Acne Prior Authorization form.

AUTHORIZATION:

60 day trial on a topical tretinoin.

RE-AUTHORIZATION:

Documentation indicating patient has had at least a 25% improvement or more from the baseline. Re-authorization is then for 6 months.

1/13/11

<https://medicaid.utah.gov/pharmacy/>