BlueCross BlueShield of North Carolina

Topical Androgen Receptor Inhibitors - NC Standard
WINLEVI® (clascoterone 1% cream)
PRIOR REVIEW/CERTIFICATION FAXBACK FORM

INCOMPLETE FORMS MAY DELAY PROCESSING

ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT Blue Cross NC PROVIDER ID# BELOW

PRESCRIBER NAME	PRESCRIBER NPI [REQUIRED]	Blue Cross NC PROV ID # / TAX ID [out of state]

CONTACT PERSON	PRESCRIBER PHONE	PRESCRIBER FAX

PRESCRIBER ADDRESS	CITY	STATE	ZIP

PATIENT NAME	Blue Cross NC ID	DATE OF BIRTH	GENDER
			M F

Please answer the following questions: **Diagnosis Code:** _____

1. Is the patient 12 years of age or older?..... ☐ Yes ☐ No
2. Does the patient have a diagnosis of acne vulgaris?..... ☐ Yes ☐ No
3. Has the patient tried and failed any of the following medications:
   a. Generic benzoyl peroxide?..... ☐ Yes ☐ No
   b. Generic adapalene?..... ☐ Yes ☐ No
   c. Generic tretinoin?..... ☐ Yes ☐ No
4. Does the patient have a contraindication / intolerance to any of the following medications:
   a. Generic benzoyl peroxide?..... ☐ Yes ☐ No
   b. Generic adapalene?..... ☐ Yes ☐ No
   c. Generic tretinoin?..... ☐ Yes ☐ No
5. Is the patient female?..... ☐ Yes ☐ No
   IF YES, please answer the following questions:
   a. Has the patient tried and failed any of the following medications:
      i. Generic combined oral contraceptive (COC)?..... ☐ Yes ☐ No
      ii. Generic spironolactone?..... ☐ Yes ☐ No
   b. Does the patient have a contraindication / intolerance to generic combined oral contraceptive (COC) AND generic spironolactone?..... ☐ Yes ☐ No
6. Please list additional medications the patient has tried and failed, or has a contraindication / intolerance to for this diagnosis *(omission of information indicates N/A or none)*: _____
   _____

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(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information. I further understand that if Blue Cross NC determines this information is not reflected in my patient's medical records, Blue Cross NC may request a refund of any payments made and/or pursue any other remedies available.

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

For Blue Cross NC members, fax form to 1-800-795-9403