



Date _____

Client _____

PRIOR AUTHORIZATION QUESTIONNAIRE- ATRALIN GEL™

<i>M.D. Last Name:</i> _____	<i>M.D. First Name:</i> _____
<i>Physician Phone:</i> _____	<i>Physician Fax:</i> _____
<i>Patient</i> _____	<i>ID#</i> _____ <i>DOB</i> _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

1. Please check the patient's diagnosis:

- Acne vulgaris
- Other

If the diagnosis is OTHER, list the diagnosis: _____
Please attach a study showing safety and efficacy data to support the use of Atralin for this diagnosis.

2. List dates, and attach chart notes to document member's failure on a generic tretinoin product:

Drug Used/Failed: _____

Dates used: _____

- | | | |
|--|-----|----|
| 3. Is the patient 10 years of age or older? | Yes | No |
| 4. Is the patient a female who is pregnant or planning to become pregnant? | Yes | No |

Physician Signature or name of person providing answers _____

Physician Comments _____

Send or Fax completed form to:
877-329-7279

RESTAT
P.O. BOX 758
WEST BEND, WI 53095

www.restat.com

QUESTIONS PLEASE CALL:
877-526-9906