Prior Authorization Form

Solodyn Step Therapy

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Minolira, Solodyn Step Therapy .

Drug Name (select from list of drugs shown)

Minocycline HCl ER Minolira (minocycline ER) Solodyn (minocycline ER)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1.	Is the patient 12 years of age or older with a diagnosis of inflammatory, non-nodular moderate to severe acne vulgaris?	Y N
2.	Has the patient experienced an intolerance to generic minocycline (immediate-release) due to an adverse event (examples: rash, nausea, vomiting, anaphylaxis) that is thought to be due to an inactive ingredient?	Y N
3.	Has the patient experienced an inadequate treatment response to generic doxycycline (immediate-release or delayed-release)?	Y N

[If yes, then no further questions.]

4.	Has the patient experienced an intolerance to generic doxycycline (immediate-release or delayed-release)?	Y N
	[If yes, then no further questions.]	
5.	Does the patient have a contraindication that would prohibit a trial of generic doxycycline (immediate-release or delayed-release)?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date