

ORAL TETRACYCLINE DERIVATIVES PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today’s Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient’s Diagnosis - ICD code plus description:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
For all requests:	
1. Is the patient currently treated with the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Has the patient been treated with the requested agent within the past 90 days (starting on samples is NOT approvable)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, is the patient at risk if therapy is changed?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please explain risk: _____	
3. Does the patient have any FDA labeled contraindications to the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please specify contraindications: _____	
4. Is the requested agent being used off-label for the treatment of a tick-borne disease?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
5. Is the patient’s age within FDA label for the requested indication for the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
If no, please provide support for using the requested agent for the patient’s age for the requested indication: _____	
5. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat the cancer?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
6. Has the patient been diagnosed with stage four advanced, metastatic cancer and the requested agent is being used to treat an associated condition related to stage four advanced metastatic cancer? Please note, chart notes are required. <input type="checkbox"/> Yes <input type="checkbox"/> No	
7. If yes to either of the previous two questions, is the use of the requested agent consistent with best practices for the treatment of stage four advanced, metastatic cancer, or an associated condition; supported by peer-reviewed, evidence-based literature; and approved by the United States Food and Drug Administration?..... <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please continue to the next page.	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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8. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____

For acne requests:

9. Will the patient be using a benzoyl peroxide OR a retinoid agent in combination with the requested agent? Yes No
 If no, does the patient have an intolerance, hypersensitivity, or FDA labeled contraindication to a benzoyl peroxide agent or a retinoid agent?..... Yes No
 If yes, please explain: _____

For acne or rosacea requests:

10. Will the patient be using the requested agent in combination with another tetracycline derivative for the treatment of acne OR rosacea?..... Yes No

Target Agents	Prerequisite Agents
Doxycycline Agents	
doxycycline monohydrate capsule (75 mg and 150 mg) Doryx (doxycycline hyclate delayed-release tablet) Doryx MPC (doxycycline hyclate delayed-release tablet) doxycycline hyclate tablet (50 mg, 75 mg, 150 mg) Doxycycline hyclate delayed release tablet Oracea (doxycycline delayed-release capsule) Vibramycin (doxycycline hyclate capsule, monohydrate suspension)	generic doxycycline hyclate (tablet [20 mg, 100 mg], capsule) generic doxycycline monohydrate (capsule [50 mg, 100 mg], tablet, suspension)
Minocycline Agents	
Emrosi (minocycline hydrochloride extended-release capsule) minocycline hydrochloride tablet (75 mg, 100 mg) Minocycline extended-release capsule Minocycline extended-release tablet Solodyn (minocycline extended-release tablet) Ximino (minocycline extended-release capsule)	Any ONE of the following: generic doxycycline hyclate (tablet [20 mg, 100 mg], capsule) generic doxycycline monohydrate (capsule [50 mg, 100 mg], tablet, suspension) AND generic minocycline hydrochloride (tablet [50 mg], capsule)
Other Agents	
Seysara (sarecycline tablet)	generic doxycycline hyclate (tablet [20 mg, 100 mg], capsule) generic doxycycline monohydrate (capsule [50 mg, 100 mg], tablet, suspension)
Tetracycline Agents	
Tetracycline tablet	Any ONE of the following: generic doxycycline hyclate (tablet [20 mg, 100 mg], capsule) generic doxycycline monohydrate (capsule [50 mg, 100 mg], tablet, suspension) AND generic tetracycline hydrochloride 250 mg and 500 mg capsule

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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For targeted doxycycline agent or Seysara requests:

• **Please submit chart notes to support the answers to the following questions:**

11. Has the patient tried and had an inadequate response to ONE prerequisite agent in the past 90 days? Yes No
12. Was ONE prerequisite agent discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
13. Does the patient have an intolerance or hypersensitivity to ONE prerequisite agent that is not expected to occur with the requested agent?..... Yes No
14. Does the patient have an FDA labeled contraindication to ALL prerequisite agents that is not expected to occur with the requested agent?..... Yes No
15. Is ONE prerequisite agent expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm?..... Yes No
16. Is ONE prerequisite agent not in the best interest of the patient based on medical necessity?..... Yes No
17. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as ONE prerequisite agent and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
18. Is there support that ALL prerequisite agents are NOT appropriate for the requested indication? Yes No
If yes, please provide supporting information: _____

For targeted minocycline agent or tetracycline agent requests:

• **Please submit chart notes to support the answers to the following questions:**

19. Has the patient tried and had an inadequate response to TWO prerequisite minocycline agents in the past 180 days? Yes No
20. Were TWO prerequisite agents discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
21. Does the patient have an intolerance or hypersensitivity to TWO prerequisite agents that is not expected to occur with the requested agent?..... Yes No
22. Does the patient have an FDA labeled contraindication to ALL prerequisite agents that is not expected to occur with the requested agent?..... Yes No
23. Are TWO prerequisite agents expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm?..... Yes No
24. Are TWO prerequisite agents not in the best interest of the patient based on medical necessity?..... Yes No
25. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as TWO prerequisite agents and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? Yes No
26. Is there support that ALL prerequisite agents are NOT appropriate for the requested indication? Yes No
If yes, please provide supporting information: _____

Please fax or mail this form to:
 Prime Therapeutics LLC
 Clinical Review Department
 2900 Ames Crossing Road Suite 200
 Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
BCBSIL: 800.285.9426
BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

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