

TETRACYCLINES (formerly ACNE AGENTS, ORAL) PRIOR AUTHORIZATION FORM

- Please submit **all** requested documentation with this request. Incomplete documentation may delay the processing of this request.
- To review the prior authorization guidelines for Oral Acne Agents, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Acne Agents, Oral** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info (PA# _____)	# of pages in request: _____	Prescriber name:
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/State/Zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested			
<input type="checkbox"/> Adoxa capsule	<input type="checkbox"/> doxycycline hyclate DR tablet	<input type="checkbox"/> minocycline ER tablet	<input type="checkbox"/> Solodyn tablet
<input type="checkbox"/> demeclocycline tablet	<input type="checkbox"/> doxycycline monohydrate 75 mg capsule	<input type="checkbox"/> Morgidox capsule	<input type="checkbox"/> tetracycline capsule
<input type="checkbox"/> Doryx DR tablet	<input type="checkbox"/> doxycycline monohydrate 150 mg capsule	<input type="checkbox"/> Morgidox kit	<input type="checkbox"/> Vibramycin capsule
<input type="checkbox"/> doxycycline <u>hyclate</u> tablet	<input type="checkbox"/> doxycycline monohydrate suspension	<input type="checkbox"/> Oracea capsule	<input type="checkbox"/> Vibramycin syrup
<input type="checkbox"/> doxycycline <u>hyclate</u> capsule	<input type="checkbox"/> minocycline tablet		
Strength:	Directions:	Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):		Dx code (<i>required</i>):	
1. Has the Recipient tried and failed any of the preferred Tetracyclines? <i>Check all that apply.</i>		<input type="checkbox"/> Yes – <i>submit all supporting documentation of drug regimen and therapeutic failure.</i>	
<input type="checkbox"/> doxycycline monohydrate <u>50 mg</u> or <u>100 mg</u> capsule <input type="checkbox"/> doxycycline monohydrate <u>tablet</u> <input type="checkbox"/> minocycline <u>capsule</u> <input type="checkbox"/> Vibramycin <u>suspension</u>		<input type="checkbox"/> No	
2. Does the Recipient have any contraindications or intolerances to the preferred agents listed in question (1)?		<input type="checkbox"/> Yes – <i>submit all supporting documentation of medication name(s) and associated intolerances and contraindications.</i>	
		<input type="checkbox"/> No	

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
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