US Family Health Plan

Prior Authorization Request Form for

Tetracyclines

(Acticlate, Avidoxy, Doryx [doxycycline hyclate], Doryx MPC, Targadox, Minocin, Morgidox, Oracea [doxycycline monohydrate 40mg IR/DR] generic and doxycycline monohydrate 40mg IR/DR, Mondoxyne NL, Adoxa, Monodox, Vibramycin, Okebo)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be **faxed** to **855-273-5735**

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Initial and renewal prior authorization expires after 12 months. **usfamilyhealth.org/rx-pa**

Step 1

Please complete patient and physician information (please print):

Patient Name: _____ Physician Name: _____

Address: _____ Address: _____

_____ _____

Sponsor ID # _____ Phone #: _____

Date of Birth: Secure Fax #:

Step 2

Please complete the clinical assessment:

1. Is this request for continuation of therapy?	☐ Yes proceed to question **12**	☐ No proceed to question **2**
2. Is the requested medication being used for acne vulgaris or rosacea?	☐ Yes proceed to question **6**	☐ No proceed to question **3**
3. Is the requested medication being used for the treatment of a susceptible infection?	☐ Yes proceed to question **4**	☐ No **STOP** **Coverage not approved**

4. What medication is being requested?

- ☐ Doryx (generic doxycycline hyclate 50, 100, 150, 200 mg DR) - proceed to **5**
- ☐ Doryx MPC - proceed to **5**
- ☐ Acticlate - proceed to **5**
- ☐ Minocin - proceed to **5**
- ☐ Vibramycin - proceed to **5**
- ☐ Okebo - proceed to **5**
- ☐ All others – **STOP - Coverage not approved**

5. Has the patient failed or had clinically significant adverse events to generic immediate-release doxycycline?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Continue on next page

6. What medication is being requested?	☐ Acticlate - proceed to **7** ☐ Doryx (generic doxycycline hyclate 50, 100, 150, 200 mg DR) -proceed to **7** ☐ Doryx MPC - proceed to **7** ☐ Targadox - proceed to **7** ☐ Monodox - proceed to **7** ☐ Morgidox - proceed to **7** ☐ Mondoxyne NL - proceed to **7** ☐ Oracea and generic doxycycline monohydrate 40mg IR/DR - proceed to **9** ☐ Adoxa – proceed to **7** ☐ Avidoxy – proceed to **7** ☐ Minocin – proceed to **7** ☐ Vibramycin – proceed to **7** ☐ Okebo – proceed to **7** ☐ All others – **STOP - Coverage not approved**

7. Has the patient tried and had an inadequate response to or failed to tolerate one generic immediate-release doxycycline product (hyclate or monohydrate salt)?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Has the patient tried and had an inadequate response to or failed to tolerate one generic immediate-release minocycline product?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
9. Does the patient have rosacea with inflammatory lesions (papules and pustules) or ocular rosacea symptoms?	☐ Yes proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Has the patient tried generic immediate-release doxycycline (does not include doxycycline 40 mg IR/DR) and had an inadequate response or could not tolerate it due to gastrointestinal adverse events?	☐ Yes proceed to question **11**	☐ No **STOP** **Coverage not approved**
11. Has the patient failed topical rosacea treatments, including metronidazole 1% gel?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
12. Has the patient's therapy been re-evaluated within the last 12 months?	☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**

13. Is the patient tolerating treatment and there continues to be a medical need for the medication?	☐ Yes proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Does the patient have disease stabilization or improvement in disease while on therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

_____ _____

Prescriber Signature Date

[6 March 2019]