US Family Health Plan
Prior Authorization Request Form for
minocycline 4% foam (**Amzeeq**)

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**

Prior authorization expires after 1 year**.**

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. This agent has been identified as having cost-effective alternatives including adapalene (cream, gel, and lotion), clindamycin (cream, gel, lotion, and solution), clindamycin/benzoyl peroxide (combination) gel, and tretinoin (cream, and gel). These agents are available without a PA. Please consider changing the prescription to one of these agents.	Proceed to question **2**
2. What is the indication or diagnosis?	☐ Acne Vulgaris – Proceed to question **3** ☐ Other – **STOP Coverage not approved**

3. Please explain why this agent is required and the patient cannot take the formulary alternatives.

Sign and date below

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[13 May 2020]