US Family Health Plan
Prior Authorization Request Form for
doxycycline **(Oracea)**

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 approval expires after 1 year. For renewal of therapy an initial USFHP prior authorization approval is required.

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:**

Question		
1. **The following agents are available without a prior authorization: doxycycline IR 20mg tablet, doxycycline 50mg and 100mg capsule or tablet, and metronidazole 1% gel. Please consider changing the prescription to one of these preferred agents.**	☐ Acknowledged Proceed to question **2**	
2. **Has the patient received this medication under the USFHP benefit in the last 6 months?** *Please choose "No" if the patient did not previously have a approved PA for Oracea.*	☐ Yes (subject to verification) Proceed to question **6**	☐ No Proceed to question **3**
3. **Is the patient greater than or equal to 18 years of age?**	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. **Does the patient have a diagnosis of rosacea with inflammatory lesions (papules and pustules)? Note: Non-FDA-approved uses are NOT approved.**	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. **Please explain why the patient requires Oracea and cannot take the available alternatives? The available alternative agents are doxycycline IR 20mg tablet, doxycycline 50mg and 100mg capsule or tablet, and metronidazole 1% gel.**	______________________ **Sign and date below**	
6. **Does the prescriber acknowledge that Oracea efficacy beyond 16 weeks and safety beyond 9 months have not been established?**	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

7.	**Has the patient's therapy been reevaluated within the last 12 months (unless re-evaluation is not clinically appropriate)?**	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8.	**Is the patient tolerating treatment and there continues to be a medical need for Oracea?**	☐ Yes Proceed to question **9**	☐ No **STOP** **Coverage not approved**
9.	**Does the patient have disease stabilization or improvement in disease while on therapy? (as defined by standard parameters for the patient's condition)?**	☐ 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

[29 July 2020]