

US Family Health Plan
 Prior Authorization Request Form for
Generic minocycline ER, Ximino ER, Coremino ER, Minolira ER, Seysara

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

Step 1 Please complete patient and physician information (please print):

Patient Name: _____ Address: _____ Sponsor ID #: _____ Date of Birth: _____	Physician Name: _____ Address: _____ Phone #: _____ Secure Fax #: _____
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Step 2 Please complete the clinical assessment:

1. Is this request for Seysara?	<input type="checkbox"/> Yes Proceed to question 3	<input type="checkbox"/> No Proceed to question 2
2. Has the patient received this medication under the TRICARE benefit in the last 6 months? Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested medication.	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No Proceed to question 3
3. Does the patient have acne with inflammatory lesions?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No STOP Coverage not approved
4. Is the patient unable to tolerate generic minocycline IR due to gastrointestinal adverse events?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
5. Has the patient's therapy been re-evaluated within the last 12 months?	<input type="checkbox"/> Yes Proceed to question 6	<input type="checkbox"/> No STOP Coverage not approved
6. Is the patient tolerating treatment and there continues to be a medical need for the medication?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No STOP Coverage not approved

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7. Does the patient have disease stabilization or improvement in disease while on therapy?	<input type="checkbox"/> Yes Sign and date below	<input type="checkbox"/> No STOP Coverage not approved
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Step 3 I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature

Date