

Prior Authorization Request Form for  
minocycline 4% foam (**Amzeeq**)



JOHNS HOPKINS  
HEALTHCARE

7231 Parkway Drive, Suite 100, Hanover, MD 21076

**FAX Completed Form and  
Applicable Progress Notes to:  
(410) 424-4037**

# USFHP Pharmacy Prior Authorization Form

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

**Questions?** Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

**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?	<input type="checkbox"/> Acne Vulgaris – Proceed to question 3 <input type="checkbox"/> Other – <b>STOP Coverage not approved</b>
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

For Internal Use Only	
<input type="checkbox"/> Approved:	Duration of Approval: _____month(s)
<input type="checkbox"/> Denied:	Authorized By:
<input type="checkbox"/> Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: