Prior Authorization Request Form for
generic minocycline ER, Ximino ER, Solodyn, Coremino ER, Minolira ER, Seysara

JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

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

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:**

Question	Yes	No
1. Is this request for continuation of therapy?	☐ Yes Proceed to question 4	☐ No Proceed to question 2
2. Does the patient have acne with inflammatory lesions?	☐ Yes Proceed to question 3	☐ No **STOP** **Coverage not approved**
3. Is the patient unable to tolerate generic minocycline IR due to gastrointestinal adverse events?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
4. Has the patient's therapy been re-evaluated within the last 12 months?	☐ Yes Proceed to question 5	☐ No **STOP** **Coverage not approved**
5. Is the patient tolerating treatment and there continues to be a medical need for the medication?	☐ Yes Proceed to question 6	☐ No **STOP** **Coverage not approved**
6. 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

[25 January 2019]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: