CareFirst
The CareFirst BlueCross BlueShield family of health care plans

CVS/caremark

Prior Authorization Form

CAREFIRST

Solodyn Step Therapy (Brand Only)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Solodyn Step Therapy (Brand Only).

Drug Name (select from list of drugs shown)
Solodyn Tablets *Brand Only* (minocycline ER)

Quantity | Frequency | Strength

Route of Administration | Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1.	Is the patient 12 years of age or older with a diagnosis of inflammatory, non-nodular moderate to severe acne vulgaris?	Y N
2.	Has the patient experienced an inadequate treatment response with generic minocycline extended-release or minocycline or doxycycline extended-release or doxycycline after a trial of at least 30 days?	Y N
	[If yes, then no further questions.]	
3.	Has the patient experienced an intolerance, contraindication to or a potential drug interaction with generic minocycline extended-release or minocycline AND doxycycline extended-release or doxycycline that would prohibit a 30 day trial?	Y N
4.	Has the patient experienced an inadequate treatment response with tetracycline, erythromycin, trimethoprim-sulfamethoxazole, trimethoprim, or azithromycin after a trial of at least 30 days?	Y N

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I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date