

# SOLODYN STEP THERAPY

## PRIOR AUTHORIZATION REQUEST FORM

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

Complete and review information, sign and date. Fax signed form to Caremark's prior authorization department at 1-888-836-0730. The Caremark fax machine is located in a secure location as required by HIPAA regulations. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

Providers may call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures. Members should call Caremark Customer Care at 1-888-963-7290 with any questions. Members may also call their health plan at the number indicated on their Member ID cards.

**Please circle the appropriate answer for each applicable question (Y for Yes, N for No).**

1. Is the patient 12 years of age or older? Y      N  
[If the answer to this question is no, no further questions are required.]
2. Does the patient have a diagnosis of inflammatory, non-nodular moderate to severe acne vulgaris? Y      N
3. Has the patient experienced an inadequate treatment response or intolerance to a trial of generic minocycline? Y      N  
[If the answer to this question is yes, then skip to question 5.]
4. Does the patient have a documented relative contraindication to, or a potential drug interaction with a generic minocycline? Y      N
5. Has the patient experienced an inadequate treatment response or intolerance to a trial of generic tetracycline, generic doxycycline, OR generic erythromycin? Y      N  
[If the answer to this question is yes, then no further questions required.]

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6. Does the patient have a documented relative contraindication to, or a potential drug interaction with generic tetracycline, generic doxycycline, AND generic erythromycin?      Y      N

**Comments:**

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

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**Prescriber (or Authorized) Signature and Date:**