

Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Minocin (FA-PA)

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 **1-855-240-0536** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Minocin (FA-PA).

Drug Name (select from list of drugs shown)

Minocin (minocycline)

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. Preferred products are available at a lower cost. Can your patient be switched to a preferred drug/product? [If yes, provide your patient with a new prescription for the preferred product.] _____

Y N

Available Formulary Alternatives: minocycline

2. Is the requested drug being used for an FDA-Approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)? _____

Y N

3. Does the prescribed dose and quantity fall within the FDA approved labeling or within dosing guidelines found in the compendia of current literature?	☐ Y ☐ N
4. Has the patient tried and had an inadequate treatment response or intolerance to the required number of formulary alternatives below [If yes, then documentation is required for approval.] Drug Name and Reason for Failure _____	☐ Y ☐ N
Note: Formulary Alternatives should be prescribed first unless the patient is unable to use or receive treatment with the alternative. Required Formulary Alternatives: 1 in a class with only 1 alternative, minocycline	
[If yes, no further questions.]	
5. Does the patient have a contraindication to all the alternatives?	☐ Y ☐ N

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

Prescriber (Or Authorized) Signature and Date