CareFirst
The CareFirst BlueCross BlueShield family of health care plans

Solodyn® – Prior Authorization Request

Send completed form to: Case Review Unit CVS/caremark Specialty Programs Fax: 866-249-6155

CVS/caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS/caremark toll-free at 888-836-0730**. If you have questions regarding the prior authorization, please contact CVS/caremark at **888-413-2723.**

Patient Name:	**Date**:
Patient's ID:	**Patient's Date of Birth:**
Physician's Name:	
Specialty:	**NPI#:**
Physician Office Telephone:	**Physician Office Fax:**

1. What drug is being prescribed? ☐ Solodyn® ☐ Ximino® ☐ Other _____
2. What is the patient's diagnosis? _____
3. What is the ICD code? _____
4. Is the patient's condition due to adenosine deaminase (ADA) deficiency? ☐ Yes ☐ No
5. Has the patient 12 years of age or older with a diagnosis of inflammatory, non-nodular moderate to severe acne vulgaris?
   ☐ Yes ☐ No
6. 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?
   ☐ Yes ☐ No (*If yes, no further questions)*
7. 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?
   ☐ Yes ☐ No (*If no, no further questions)*
8. Has the patient experienced an inadequate treatment response with tetracycline, erythromycin, trimethoprim-sulfamethoxazole, trimethoprim, or azithromycin after a trial of at least 30 days? ☐ Yes ☐ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS/caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date: (mm/dd/yy)**

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Solodyn - 12/2014

CUT0373-1E (7/15)