Drug Coverage Review Request

Solodyn®

35045

SUPPLY ALL PRESCRIBER AND PATIENT INFORMATION

Physician

MD First Name _____

MD Last Name _____

Address _____

City _____

State _____

Zip Code _____

Phone _____

Fax _____

DEA Number (*optional*) _____

Prescriber

Cardholder ID # _____

Patient Last Name _____

Patient First Name _____

Date of Birth _____

Address _____

City _____

State _____

Zip Code _____

Phone _____

Medco manages the prescription drug benefit for your patient on behalf of his/her plan sponsor. Your patient's prescription benefit has a preferred drug list to help keep benefits affordable, and certain medications require a review for determination of coverage. The medication you have prescribed requires a coverage review. To request consideration for coverage of the nonpreferred medication, please complete the following questions and then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage for the non-preferred medication will be determined.

SECTION A — Please answer the following questions

1. **For which condition is this drug being prescribed?** (check appropriate box)
   - ☐ Treatment of inflammatory lesions in non-nodular moderate to severe acne vulgaris
   - ☐ Other

2. ☐ Yes ☐ No — Has the patient received at least TWO immediate-release, generically available minocycline products?

3. ☐ Yes ☐ No — If YES to the previous question, has the patient demonstrated intolerance to at least TWO immediate-release, generically available minocycline products?

SECTION B — Physician signature

_____ _____

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO 800.837.0959

PLEASE DO NOT FAX WITH A COVER SHEET

Location: Nevada Call Center(15) Case Id: 9999999

Form # FL41321Y

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