

Drug Coverage Review Request

Solodyn®

35045



SUPPLY ALL PRESCRIBER AND PATIENT INFORMATION

Physician

Prescriber

MD First Name	_____	Cardholder ID #	_____
MD Last Name	_____	Patient Last Name	_____
Address	_____	Patient First Name	_____
City	_____	Date of Birth	_____
State	_____	Address	_____
Zip Code	_____	City	_____
Phone	_____	State	_____
Fax	_____	Zip Code	_____
DEA Number (optional)	_____	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

- For which condition is this drug being prescribed?** (check appropriate box)
 Treatment of inflammatory lesions in non-nodular moderate to severe acne vulgaris
 Other
- Yes No Has the patient received at least TWO immediate-release, generically available minocycline products?
- 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



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