

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.

**This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.  
Allow at least 24 hours for review.**

**Section A – Member Information**

First Name:	Last Name:	Member ID:	
Address:			
City:	State:	ZIP Code:	
Phone:	DOB:	Allergies:	
Primary Insurance Information (if any):			
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____			
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____			

**Section B - Provider Information**

First Name:	Last Name:	M.D./D.O.	
Address:	City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:
Office Contact Name / Fax attention to:			

**Section C - Medical Information**

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No      If yes, what is this member's due date? _____	

**Section D – Previous Medication Trials**

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

**Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs:  
Please refer to the patient's PDL for a list of preferred alternatives**

Member First name:	Member Last name:	Member DOB:
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**Clinical and Drug Specific Information**

**ALL REQUESTS**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Has the patient failed a 3-day trial of TWO preferred agents within this drug class?</b> <i>(If yes, complete Section D above)</i>
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**DEMECLOCYCLINE**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a diagnosis of SIADH (syndrome of inappropriate antidiuretic hormone secretion)?</b>
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**DORYX / DOXYCYCLINE HYCLATE DR / DYNACIN / ORACEA / SOLODYN**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is there a clinical reason why the patient cannot use generic doxycycline, minocycline, or tetracycline?</b> <i>If yes, list reason:</i>
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**VIBRAMYCIN SUSPENSION**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a documented swallowing difficulty?</b>
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**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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