SOLODYN PA FORM

Fax Completed Form to:
866-254-0761
For questions regarding this Prior authorization, call
866-773-0695

HEALTH INFORMATION DESIGNS

Prior Authorization Vendor for ND Medicaid

Note: ND Medicaid will not pay for Solodyn without documented failure of a first line tetracycline agent.

- First line agents include: doxycycline, minocycline, and tetracycline.

Part I: TO BE COMPLETED BY PRESCRIBER

RECIPIENT NAME:	RECIPIENT MEDICAID ID NUMBER:
Recipient Date of birth: / /	
PRESCRIBER NAME:	PRESCRIBER MEDICAID ID NUMBER:
Address:	Phone: ( )
City:	FAX: ( )
State: Zip:	

REQUESTED DRUG: □ **SOLODYN**	**Requested Dosage:** (must be completed)

Qualifications for coverage:

□ Patient has failed a 90 day trial of which first line agent _____

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber Signature: Date:

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:	ND MEDICAID PROVIDER NUMBER:
Phone:	FAX:
Drug:	NDC#:

Part III: FOR OFFICIAL USE ONLY

Date: / /	Initials: _____
Approved - Effective dates of PA: From: / /	To: / /
Denied: (Reasons)	