



Precertification Request Form for Adoxa®

Precertification for Adoxa® requires completion of this form in its entirety. All requested data must be provided. Once completed the form must be signed by the medical provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126. Incomplete forms may result in denial of requested medication due to lack of needed information.

Table with 2 main columns: Provider Information and Patient Information. Rows include Physician's Name, Specialty, Mailing Address, City, State, Zip Code, Phone #, Fax #, Patient's Name, BCBSAZ Member ID, Date of Birth, Gender, Patient's Address, City, State, Zip Code.

Medication Information section with fields for Medication Name & Strength, Directions for Use & Duration, Diagnosis Code, and Diagnosis.

Section A: Provider must indicate all that apply. Includes checkboxes for age, hypersensitivity, pregnancy, breastfeeding, and generic Doxycycline intolerance/contraindications.

Section B: Provider must select indication from the following. Includes checkboxes for infection treatment/prevention, acne therapy, amebiasis therapy, malaria prophylaxis, and other.

Section C: Have you included supporting documentation (i.e. medical records) for consideration? Total number of pages you have sent with this request: \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_