An Independent Licensee
of the Blue Cross and
Blue Shield Association

Precertification Request Form for

Doryx®

Precertification for Doryx® 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.

Provider Information			Patient Information		
Physician's Name			Patient's Name		
Physician Specialty	NPI #		BCBSAZ Member ID		
Mailing Address			Date of Birth / /	Gender ☐ Male ☐ Female	
City	State	Zip Code	Patient's Address		
Phone # ( ) - ext	Fax # ( ) -		City	State	Zip Code

Medication Information

Medication Name & Strength: ______
Directions for Use & Duration: ______
Diagnosis Code: ______
Diagnosis: ______

A. Provider must indicate all that apply:

☐ Yes ☐ No Individual is above the age of 8 years

☐ Yes ☐ No Individual has no hypersensitivity or contraindication to any Tetracycline

☐ Yes ☐ No Individual is not pregnant or likely to become pregnant

☐ Yes ☐ No Individual is not breast feeding

☐ Individual cannot use generic Doxycycline because:

- ☐ individual has a non-allergic intolerance to generic Doxycycline (**reaction must be provided**):
  - ➢ Reaction: ______

OR:

- ☐ individual has an intolerance or contraindication to an excipient in generic Doxycycline (**excipient must be provided**):
  - ➢ Excipient: ______

B. Provider must select indication from the following:

☐ Yes ☐ No Treatment of infection known or strongly suspected to be caused by susceptible microorganism

☐ Yes ☐ No Prevention of infection known or strongly suspected to be caused by susceptible microorganism

☐ Yes ☐ No Adjunctive therapy for severe acne

☐ Yes ☐ No Adjunctive therapy for acute intestinal amebiasis

☐ Yes ☐ No Prophylaxis of malaria

☐ Other: ➢ Specify: ______

C. ☐ Yes ☐ No 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

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