



**BlueCross
BlueShield
of Arizona**

An Independent Licensee
of the Blue Cross and
Blue Shield Association

**Precertification Request Form for
Oracea®**

Precertification for Oracea® 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 <input type="checkbox"/> Male <input type="checkbox"/> 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.	<p>Provider must indicate all that apply:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Individual is above the age of 18 years</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Medication is not being used for treatment or prophylaxis of an infectious process</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Individual does not have other forms of rosacea (such as generalized erythema of rosacea, erythematotelangiectatic rosacea, phymatous rosacea, or ocular rosacea)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Individual does not any variant forms of rosacea (such as granulomatous rosacea or rosacea fulminans)</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Individual has no hypersensitivity or contraindication to any Tetracycline</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Individual is not pregnant or likely to become pregnant</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Individual is not breast feeding</p> <p><input type="checkbox"/> Individual cannot use generic Doxycycline because:</p> <p style="padding-left: 20px;"><input type="checkbox"/> individual has a non-allergic intolerance to generic Doxycycline (reaction must be provided):</p> <p style="padding-left: 40px;">➤ Reaction: _____</p> <p style="padding-left: 20px;">OR:</p> <p style="padding-left: 20px;"><input type="checkbox"/> individual has an intolerance or contraindication to an excipient in generic Doxycycline (excipient must be provided):</p> <p style="padding-left: 40px;">➤ Excipient: _____</p>
B.	<p>Provider must select indication from the following:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No Individual has diagnosis of Papulopustular Rosacea</p> <p><input type="checkbox"/> Other: ➤ Specify: _____</p>
C.	<p><input type="checkbox"/> Yes <input type="checkbox"/> No Have you included supporting documentation (i.e. medical records) for consideration?</p> <p>Total number of pages you have sent with this request: _____</p>

Physician's Signature	Date
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