



Date \_\_\_\_\_

Client \_\_\_\_\_

### PRIOR AUTHORIZATION QUESTIONNAIRE-ORACEA®

*M.D. Last Name:* \_\_\_\_\_ *M.D. First Name:* \_\_\_\_\_

*Physician Phone:* \_\_\_\_\_ *Physician Fax:* \_\_\_\_\_

*Patient* \_\_\_\_\_ *ID#* \_\_\_\_\_ *DOB* \_\_\_\_\_

**\*\*FAILURE TO COMPLETE THE FORM MAY RESULT IN AN AUTOMATIC DENIAL\*\***

1. Diagnosis:

- Treatment of inflammatory lesions (papules and pustules) of rosacea
- Other (please specify): \_\_\_\_\_

2. Does the patient have a known hypersensitivity to doxycycline or any other tetracyclines? Yes No

3. Is the patient 18 years of age or older? Yes No

4. Is the patient pregnant? Yes No

5. Is this a new medication for the patient? Yes No

- a. If Yes, proceed to Question #6
- b. If No, provide the date therapy was initiated \_\_\_\_\_

6. Has the patient tried and failed a course of generic doxycycline? Yes No

- a. If Yes, provide dates of trial \_\_\_\_\_
- b. If No, provide the rationale for non-trial \_\_\_\_\_

7. Physician Signature or name of person providing answers \_\_\_\_\_

Physician Comments \_\_\_\_\_

Send or Fax completed form to:  
**877-329-7279**

RESTAT  
11900 W. Lake Park Dr.  
Milwaukee, WI 53224

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