



Date _____

Client _____

PRIOR AUTHORIZATION QUESTIONNAIRE-SOLODYN®

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:

- Inflammatory lesions of non-nodular moderate to severe acne vulgaris
- Other (please specify): _____

2. Does the patient have a known hypersensitivity to any of the tetracyclines? Yes No

3. Is the patient 12 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 minocycline? Yes No

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

7. Dose Requested:

- Solodyn 45 mg Solodyn 65 mg Solodyn 90 mg
- Solodyn 115 mg Solodyn 135 mg

8. Patient's Weight: _____ LBS/KG

9. 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

QUESTIONS PLEASE CALL:
877-526-9906

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