SEYSARA® (sarecycline) Referral Form

PHONE: 888-412-9325 FAX: 877-329-9325 eRx NPI: 1093424905 www.zealsp.com

Zeal Specialty Pharmacy

Remove above portion before faxing. Please complete the form in its entirety and fax with requested clinicals to the number above.

SEY25-01

PATIENT INFORMATION

First Name	Last Name	Date of Birth ____ /____ / ____	Gender ☐ Male ☐ Female
Address	City	State	Zip
email	Home Phone	Cell Phone	

PRESCRIBER INFORMATION

Prescriber Full Name		Prescriber Credential	
Practice Address	City	State	Zip
Office email	Office Phone	Office Fax	Cell Phone
Practice Contact Person	Prescriber NPI	Preferred Contact Method ☐ Email ☐ Phone ☐ Fax	

CLINICAL INFORMATION – *please include any relevant office visit/lab notes to support this prescription*

Patient is ☐ Naïve / New Start ☐ Therapy Restart ☐ Existing Treatment | Therapy Start Date ____ /____ / ____

Allergies ☐ NKDA ☐ Drug Allergies (please list) History of hypersensitivity to tetracyclines ☐ Yes ☐ No

Therapies Tried and Failed (please check name and include dates)

☐ Oral Isotretinoin Date ____ /____ / ____
☐ Doxycycline Date ____ /____ / ____
☐ Minocycline Date ____ /____ / ____
☐ Topical Retinoid (tretinoin, adapalene, tazarotene, trifarotene) Date ____ /____ / ____
☐ Topical anti-inflammatory agent (dapsone, Winlevi, Azelaid acid) Date ____ /____ / ____
☐ Combination retinoid/benzoyl peroxide (Twyneo) Date ____ /____ / ____
☐ Other: Date ____ /____ / ____

Current Medications (please list name and dose)

Potential drug interactions (check if patient is concurrently being treated with):

☐ Oral retinoids ☐ Antacids and iron preparations ☐ Penicillin
☐ Anticoagulants ☐ P-glycoprotein substrates

ICD-10 Code ☐ L70.0 Acne vulgaris of skin
☐ Other: _____

Indication Demographics:

Patient is ≥9 years old ☐ Yes ☐ No

Patient weight (kg):

Reason for therapeutic failure/therapy not tried

☐ Adverse Reactions (local skin reaction, photosensitivity, other)
☐ Adherence concerns
☐ History of intestinal disorders
☐ History of eczema
☐ History of asthma
☐ Pre-existing esophageal disorder (GERD)
☐ History of glucose-6-phosphate dehydrogenase (G6PD) or Congenital/idiopathic methemoglobinemia
☐ Other

PRESCRIPTION – *please check all boxes across row*

Medication	Dose (patient weight)	Directions	Quantity/Day Supply	Refills
☐ **SEYSARA®** (sarecycline)	☐ 60 mg (33-54 kg) ☐ 100 mg (55-84 kg) ☐ 150 (85-136 kg)	Take one tablet once daily with or without food	☐ 30 for 30 days ☐ _____	☐ 11 ☐ _____

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.
I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature: _____ ☐ MD ☐ DO ☐ PA ☐ CRNP **Date:** ____ /____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

Note: *The information contained in this document will become a legal prescription. Prescriber is to comply with all state-specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state-specific requirements could result in outreach to the prescriber.*

SHIPPING INFORMATION

Ship to: ☐ Patient ☐ Physician/Clinic	Date Shipment Needed By: ____ /____ / ____