Please complete ALL information below and fax your request to 1-888-671-5285

Duexis® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Osteoarthritis
❑ Rheumatoid arthritis
❑ Other diagnosis: ____________________________________ ICD-10 Code(s): ____________________________________

Clinical information:

Does the patient have a history of peptic ulcer disease? ❑ **Yes** ❑ **No**
Does the patient have a history of gastrointestinal (GI) bleeding, obstruction, or perforation? ❑ **Yes** ❑ **No**
Does the patient have erosive esophagitis? ❑ **Yes** ❑ **No**
Is the patient using Duexis in combination with aspirin? ❑ **Yes** ❑ **No**

Select the nonsteroidal anti-inflammatory drugs (NSAIDs) the patient has a trial and failure or intolerance to:

❑ Diclofenac
❑ Etodolac
❑ Fenoprofen
❑ Flurbiprofen
❑ Ibuprofen
❑ Indomethacin
❑ Ketoprofen
❑ Ketorolac
❑ Meloxicam
❑ Nabumetone
❑ Naproxen
❑ Oxaprozin
❑ Piroxicam
❑ Sulindac
❑ Tolmetin

Select the H2-receptor antagonist(s) the patient has a trial and failure or intolerance to:

❑ Cimetidine
❑ Famotidine
❑ Nizatidine
❑ Ranitidine

Reauthorization:
For reauthorization requests, answer the following:
Is there documentation of positive clinical response to Duexis therapy? ❑ **Yes** ❑ **No**

Quantity limit requests:
What is the quantity requested per DAY? _________

What is the reason for exceeding the plan limitations?
❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: ____

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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

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Please note: This request may be denied unless all required information is received.

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