



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

### Duexis® Prior Authorization Request Form

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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:
<input type="checkbox"/> Check if <b>generic substitution</b> is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>		

Clinical Information (required)
<p><b>Select the diagnosis below:</b></p> <input type="checkbox"/> Osteoarthritis and to decrease risk of developing gastric ulcers <input type="checkbox"/> Rheumatoid arthritis and to decrease risk of developing gastric ulcers <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____
<p><b>Clinical information:</b></p> <p>Has the patient had an inadequate response to or inability to tolerate a TWO week trial of concurrent administration with ibuprofen and famotidine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Select the generic oral nonsteroidal anti-inflammatory drug (NSAID) alternatives for ibuprofen that the patient has had an inadequate response to or inability to tolerate a TWO week trial of:</b></p> <input type="checkbox"/> Celecoxib <input type="checkbox"/> Diclofenac <input type="checkbox"/> Etodolac <input type="checkbox"/> Meloxicam <input type="checkbox"/> Naproxen <input type="checkbox"/> Other(s). Please specify: _____
<p><b>Select the generic oral H2 blocker alternatives for famotidine that the patient has had an inadequate response to or inability to tolerate a TWO week trial of:</b></p> <input type="checkbox"/> Cimetidine <input type="checkbox"/> Nizatidine <input type="checkbox"/> Ranitidine <input type="checkbox"/> Other(s). Please specify: _____

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

\_\_\_\_\_

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

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