Please note: All information below is required to process this request
Mon-Fri: 5am to10pm Pacific / Sat: 6am to 3pm Pacific
For real time submission 24/7 visit www.OptumRx.com and click Health Care Professionals
OptumRx • M/S CA 106-0286 • 3515 Harbor Blvd. • Costa Mesa, CA 92626

Diclegis® Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

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 requesting **brand**	❑ Yes ❑ No **Continuation of therapy?** If "YES", answer the following:	
Directions for Use:	❑ Yes ❑ No Has member been on this medication in the last 180 days?*	
	❑ Yes ❑ No Does the prescriber confirm that the medication has been effective in treating the member's medical condition?*	

Clinical Information (required)

Your patient's pharmacy benefit program is administered by UnitedHealthcare, which uses OptumRx for certain pharmacy benefit services. Your patient's benefit plan requires that we review certain requests for coverage with the prescribing physician. This includes requests for benefit coverage beyond plan specifications. Please complete the following questions and then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the benefit plan's rules.

Select the diagnosis below:

❑ Nausea and vomiting associated with pregnancy
❑ Other diagnosis: _____

Medication history*

Please answer the following:

❑ Yes ❑ No Does the member have a documented failure or contraindication to lifestyle modifications (e.g., diet, avoidance of triggers)?

Does the member have a documented trial and failure or contraindication to the following?*

❑ Yes ❑ No Doxylamine 10mg (if doxylamine 10mg is not available use ½ of an over the counter 25mg tablet) AND pyridoxine 20mg (if pyridoxine 20mg is not available, use a 25mg tablet) four times a day for five (5) days?

❑ Yes ❑ No Dimenhydrinate (generic Dramamine 50mg) AND pyridoxine 20mg (if pyridoxine 20mg is not available, use a 25mg tablet) four times a day for five (5) days?

* May not apply to all plans

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.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.