



Health Partners Plans

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Doxylamine Succinate/Pyridoxine HCL

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. Please note any information left blank or illegible may delay the review process.

<b>Patient Name:</b>	<b>Prescriber Name:</b>	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State, Zip:	City, State, Zip:	
Member Phone:		
Drug Name:	Expedited/Urgent	
Directions:		
Patient belongs to (please check one): HEALTH PARTNERS	KIDZPARTNERS	

<b>Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:</b>	
Q1. Is the patient at least 18 years of age?	
Yes	No
Q2. Does the patient have a diagnosis of nausea and vomiting associated with pregnancy in women who do not respond to non-pharmacological intervention (such as dietary and lifestyle modifications)?	
Yes	No
Q3. Does the patient have a contraindication or failure of pyridoxine (B6) and doxylamine?	
Yes	No
Q4. Requested Duration:	
9 months	
Q5. Additional Information:	

Physician Signature

Date

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reference to the contents of this document is strictly prohibited. If you have received this telecopy in error, please notify the sender immediately to arrange for the return of this document.