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.**

Patient Name:	**Prescriber Name:**	
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

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign:
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**