US Family Health Plan Prior Authorization Request Form for doxylamine and pyridoxine (Diclegis, Bonjesta)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 617-562-5296

OR

The patient may attach the completed form to the prescription and **mail** it to: Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? Call 1-877-880-7007

Prior authorization will expire in 9 months

	Step	Please complete patient and physician information (please print):			
Sponsor ID #	1	Patient Name: F			
Date of Birth: Secure Fax #: Step Please complete the clinical assessment: I is this agent being used to manage nausea and vomiting during pregnancy? I is this agent being used to manage nausea and vomiting during pregnancy? I is this agent being used to manage nausea and vomiting during pregnancy? I is this agent being used to manage nausea and vomiting during pregnancy? I is this agent being used to manage nausea and vomiting during pregnancy? I is this agent being used to manage nausea and vomiting during pregnancy? I is this agent being used to manage nausea and vomiting during pregnancy? I is this agent being used to manage nausea and vomiting during pregnancy? I is this agent being used to manage nausea and vomiting during pregnancy? I is this agent being used to manage nausea and vomiting during pregnancy? I is this agent being used to manage nausea and vomiting during pregnancy? I is this agent being used to manage nausea and vomiting during pregnancy? I is this agent being used to manage nausea and vomiting during pregnancy? I is this agent being used to manage nausea and vomiting during pregnancy? I is this agent being used to manage nausea and vomiting during pregnancy? I is this agent being used to approved I is this agent being used to obtain relief of symptoms? I is the provider obtain relief of symptoms? I is the provider considered an alternate antiemetic prior to prescribing the requested medication (for example, ondansetron [Zofran])? I is this agent being used to approved I is this agent being used to approved I is this agent being usent tried over-the-counter (OTC) doxylamin		Address:	Address:		
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example, ondansetron [Zofran])? Sign and date below STOP		prior to prescribing the requested medication (for	□ Yes	□ No	
Coverage not approved			Sign and date below	STOP	
				Coverage not approved	

Step 3

Prescriber Signature

I certify the above is true to the best of my knowledge. Please sign and date:

Date

[22 August 2018]