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 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 Please complete the clinical assessment:

1. Is this agent being used to manage nausea and vomiting during pregnancy?	☐ Yes Proceed to question 2	☐ No **STOP** **Coverage not approved**
2. Has the patient tried at least one non-pharmacologic treatment (for example, ginger, acupressure, high-protein bedtime snack) and failed to obtain relief of symptoms?	☐ Yes Proceed to question 3	☐ No **STOP** **Coverage not approved**
3. Has the patient tried over-the-counter (OTC) pyridoxine (Vitamin B_6) and failed to obtain relief of symptoms?	☐ Yes Proceed to question 4	☐ No **STOP** **Coverage not approved**
4. Has the patient tried over-the-counter (OTC) doxylamine and failed to obtain relief of symptoms?	☐ Yes Proceed to question 5	☐ No **STOP** **Coverage not approved**
5. Has the provider considered an alternate antiemetic prior to prescribing the requested medication (for example, ondansetron [Zofran])?	☐ Yes Sign and date below	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____

[22 August 2018]