OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Duexis® Prior Authorization Request Form (Page 1 of 2)

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

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Osteoarthritis
❑ Rheumatoid arthritis
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Does the patient have a history of peptic ulcer disease? ❑ **Yes** ❑ **No**
Does the patient have a history of gastrointestinal (GI) bleeding, obstruction, or perforation? ❑ **Yes** ❑ **No**
Does the patient have erosive esophagitis? ❑ **Yes** ❑ **No**
Is the patient using Duexis in combination with aspirin? ❑ **Yes** ❑ **No**
Does the patient have a trial and failure or intolerance to **TWO** H2-receptor antagonists? ❑ **Yes** ❑ **No**

Select the medications the patient has a trial and failure or intolerance to:

❑ Etodolac
❑ Fenoprofen
❑ Flurbiprofen
❑ Ibuprofen
❑ Indomethacin
❑ Ketoprofen
❑ Ketorolac
❑ Meloxicam
❑ Nabumetone
❑ Naproxen
❑ Oxaprozin
❑ Piroxicam
❑ Sulindac
❑ Tolmetin

Reauthorization:

For reauthorization requests, answer the following:

Is there documentation of positive clinical response to Duexis therapy? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

❑ Titration or loading dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ Other: _____

Duexis® Prior Authorization Request Form (Page 2 of 2)

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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.