DSS
Strong Families - South Dakota's Foundation and Our Future

Please note: All information below is required to process this request.
Fax to 1-844-403-1029
Mon-Sat: 7am to 7pm Central

Duexis® & Vimovo® 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)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			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:

- ❑ Ankylosing spondylitis [**Vimovo** only]
- ❑ Osteoarthritis
- ❑ Rheumatoid arthritis
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Does the patient have a history of peptic ulcer disease/gastrointestinal (GI) bleed? ❑ **Yes** ❑ **No**

Does the patient have one additional risk factor for gastrointestinal adverse events (e.g., use of anticoagulants, chronic corticosteroids)? ❑ **Yes** ❑ **No**

Does the patient have a history of asthma or urticaria after taking aspirin or other NSAIDs? ❑ **Yes** ❑ **No**

For Duexis requests, please also answer the following:

Has the patient had a 30 day trial of a preferred generic H2-receptor blocker (e.g., famotidine, cimetidine, ranitidine, nizatidine) AND a generic NSAID within the last 180 days? ❑ **Yes** ❑ **No**

For Vimovo requests, please also answer the following:

Has the patient had a 30 day trial of a preferred generic proton pump inhibitor (e.g., omeprazole, lansoprazole, pantoprazole) AND a generic NSAID within the last 180 days? ❑ **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: _____

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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 1-855-401-4262.
This form may be used for non-urgent requests and faxed to 1-844-403-1029.