PRIOR AUTHORIZATION REQUEST
Topical NSAIDs for Arthritis and Pain

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested:_____ Qty Requested: _____

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please answer the following questions

1. Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?
   - ☐ INITIAL - **please answer question 2 - 9**
   - ☐ CONTINUATION - **please answer question 10**
2. ☐ Yes ☐ No Is the patient at high-risk for adverse GI events (for example, GREATER THAN or EQUAL TO 65 years of age, concomitant corticosteroid or anticoagulant use, or history of GI bleed, PUD, GERD, or gastritis)?
3. ☐ Yes ☐ No Is the patient at high-risk for other adverse effects associated with oral NSAID use (for example, CHF, renal failure, concomitant use of lithium)?
4. ☐ Yes ☐ No Has the patient tried and failed THREE of the following formulary NSAIDs: naproxen, piroxicam, diclofenac, nabumetone, ketoprofen, indomethacin, and flurbiprofen?
5. What is the medication being requested?
   - ☐ Diclofenac 1% Gel
   - ☐ Pennsaid - **please answer question 6 - 7**
   - ☐ Flector patch - **please answer question 8 - 9**
6. ☐ Yes ☐ No Is the requested medication being prescribed for osteoarthritis (OA) of the knee?
7. ☐ Yes ☐ No Has the patient tried and failed diclofenac 1% gel?
8. ☐ Yes ☐ No Is the requested medication being prescribed for acute pain from minor strains, sprains, or contusions?
9. ☐ Yes ☐ No Has the patient tried and failed diclofenac 1% gel?
10. ☐ Yes ☐ No Are the patient's symptoms improving with the medication?

Please document the diagnoses, symptoms, and/or any other information important to this review:

_____

_____

If you have any questions, call: 800-753-2851

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SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

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