maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Topical NSAIDs

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1	Is this a request for INITIAL or CONTINUATION of therapy with the requested medication? [] INITIAL (If checked, go to 2) [] CONTINUATION (If checked, go to 11)		
2	Is the patient 18 years of age or older? [If no, no further questions.]	Yes	No
3	Is the patient at high-risk for adverse gastrointestinal (GI) events (for example, GREATER THAN or EQUAL TO 65 years of age, concomitant corticosteroid or anticoagulant use, or history of GI bleed, peptic ulcer disease [PUD], gastroesophageal reflux disease [GERD], or gastritis)? [If yes, skip to question 6.]	Yes	No

If you have any questions, call:
1-888-258-8250

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4	Is the patient at high-risk for other adverse effects associated with oral non-steroidal anti-inflammatory (NSAID) use (for example, congestive heart failure [CHF], renal failure, concomitant use of lithium)? [If yes, skip to question 6.]	Yes	No
5	Has the patient tried and failed THREE of the following formulary non-steroidal anti-inflammatory drugs (NSAIDs): A) naproxen, B) piroxicam, C) diclofenac, D) nabumetone, E) ketoprofen, F) indomethacin, G) flurbiprofen? [If no, no further questions.]	Yes	No
6	Which medication is being requested? [] Diclofenac 1% gel (If checked, no further questions) [] Pennsaid (If checked, go to 7) [] Flector patch (If checked, go to 9)		
7	Is the requested medication being prescribed for osteoarthritis (OA) of the knee? [If no, no further questions.]	Yes	No
8	Has the patient tried and failed diclofenac 1% gel? [No further questions.]	Yes	No
9	Is the requested medication being prescribed for acute pain from minor strains, sprains, or contusions? [If no, no further questions.]	Yes	No
10	Has the patient tried and failed diclofenac 1% gel? [No further questions.]	Yes	No
11	Are the patient's symptoms improving with the medication? [If no, no further questions.]	Yes	No
12	What is the medication being requested? [] Diclofenac 1% gel (If checked, no further questions) [] Pennsaid (If checked, no further questions) [] Flector patch (If checked, no further questions)		

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

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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