UnitedHealthcare Community Plan

Topical NSAIDs - Arizona
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS

□ Yes □ No	**Did the patient receive inadequate pain relief when treated with any of the following preferred non-steroidal anti-inflammatory drugs [NSAIDs] (an inadequate response to treatment is defined as pain and/or inflammatory symptoms not resolved after 14 days of therapy)?** *(If yes, check which applies and complete Section D above)* □ Diclofenac DR (Generic Voltaren) □ Diclofenac ER (Generic Voltaren ER) □ Etodolac (Generic Lodine) □ Etodolac ER (Generic Lodine ER) □ Fenoprofen (Generic Nalfon) □ Flurbiprofen (Generic Ansaid) □ Ibuprofen □ Indomethacin (Generic Indocin) □ Ketorolac (Generic Toradol) □ Mefenamic (Generic Ponstel) □ Meloxicam (Generic Mobic) □ Nabumetone (Generic Relafen) □ Nabumetone DS (Generic Relafen DS) □ Naproxen (Generic Anaprox) □ Naproxen DR (Generic Anaprox DR) □ Naproxen EC (Generic Anaprox EC) □ Oxaprozin (Generic Daypro) □ Piroxicam (Generic Feldene) □ Sulindac (Generic Clinoril)
□ Yes □ No	**Does the patient have any of the following risk factors for NSAID-induced adverse GI (gastrointestinal) events?** *(If yes, check which applies)* □ Patient is greater than or equal to 65 years of age □ Prior history of peptic, gastric, or duodenal ulcer □ History of NSAID-related ulcer □ History of clinically significant GI (gastrointestinal) bleeding □ Untreated or active H. Pylori gastritis □ Concurrent use of oral corticosteroids (e.g., prednisone, prednisolone, dexamethasone) □ Concurrent use of anticoagulants (e.g., warfarin, heparin) □ Concurrent use of antiplatelets (e.g., aspirin including low-dose, clopidogrel)

FLECTOR PATCH/DICLOFENAC EPOLAMINE 1.3% PATCH

□ Yes □ No	**Does the patient have a diagnosis of acute pain due to minor strains, sprains, or contusions?**

DICLOFENAC 1% GEL (RX FORMULATION)/VOLTAREN OTC

□ Yes □ No	**Does the patient have a diagnosis of pain due to osteoarthritis of joints amenable to topical treatment, including but not limited to, the hands, knees, ankles, elbows, feet, and wrists?**

PENNSAID 2%/DICLOFENAC 1.5% SOLUTION

□ Yes □ No	**Does the patient have a diagnosis of pain due to osteoarthritis of the knee(s)?**
□ Yes □ No	**Does the patient have a history of failure, intolerance, or contraindication to diclofenac topical gel 1% (Rx formulation), or Voltaren OTC (over the counter)?** *(If yes, complete Section D above)*

Provider Signature: _____ **Date:** _____