

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: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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**

Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

ALL REQUESTS

<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient taking aspirin or any other nonsteroidal anti-inflammatory drugs (NSAIDs)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of therapeutic failure, intolerance, or contraindication to the preferred nonsteroidal anti-inflammatory drugs (NSAIDs)? <i>(If yes, complete Section D above)</i>
FLECTOR (DICLOFENAC EPOLAMINE) PATCH / PENNSAID PUMP / BRAND VOLTAREN GEL	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient had therapeutic failure of two (2) preferred oral generic nonsteroidal anti-inflammatory drugs (NSAIDs), contraindication, or intolerance of the preferred oral generic NSAIDs? <i>(If yes, complete Section D above)</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is there support for the transdermal formulation as the medically necessary route of administration?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Has the patient had a therapeutic failure or contraindication of the preferred topical NSAID analgesic? <i>(If yes, complete Section D above)</i>
KETOROLAC INJECTABLE / READYSHARP KETOROLAC KIT	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the requested medication being prescribed for self-administration?
SPRIX	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient have a history of therapeutic failure, intolerance, or contraindication to oral ketorolac? <i>(If yes, complete Section D above)</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Does the patient weigh less than 50 kilograms?
<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the patient renally impaired?

Provider Signature: _____ **Date:** _____

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