ROCKY MOUNTAIN HEALTH PLANS®
A UnitedHealthcare Company

Topical NSAIDs - Colorado
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 preferred non-steroid anti-inflammatory drugs (NSAIDs)?** *(If yes, complete Section D above)*
□ **Yes** □ **No**	**Does the patient have any of the following risk factors?** *(If yes, check which applies)* □ Concurrent use of anticoagulants (e.g., warfarin, heparin) □ Concurrent use of antiplatelets (e.g., aspirin including low-dose, clopidogrel) □ Concurrent use of oral corticosteroids (e.g., prednisone, prednisolone, dexamethasone) □ History of clinically significant GI bleeding □ History of NSAID-related ulcer □ Patient is 65 years of age or greater □ Prior history of peptic, gastric, or duodenal ulcer □ Untreated or active *H. Pylori* gastritis
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?**
VOLTAREN & DICLOFENAC SODIUM 1% GEL	
□ **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, ankle, elbows, feet and wrists?**
PENNSAID & DICLOFENAC SODIUM 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 1% gel?** *(If yes, complete Section D above)*

Provider Signature: _____ **Date:** _____