UnitedHealthcare Community Plan

Topical NSAIDs
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 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)* □ The patient is 60 years of age or greater □ The patient has a previous clinical history of gastroduodenal ulcer, gastrointestinal bleeding, or gastroduodenal perforation □ Concomitant use of chronic systemic corticosteroids, anticoagulants, or anti-platelet agents
FLECTOR PATCH	
□ **Yes** □ **No**	**Does the patient have a diagnosis of acute pain due to minor strains, sprains, or contusions?**
VOLTAREN GEL AND PENNSAID	
□ **Yes** □ **No**	**Does the patient have a diagnosis of osteoarthritis of joints amenable to topical treatment, including, but not limited to, the hands, knees, ankle, elbows, feet and wrists?**
□ **Yes** □ **No**	**Does the patient have a diagnosis of osteoarthritis of the knee(s)?**
□ **Yes** □ **No**	**Does the patient have a history of failure, intolerance, or contraindication to generic Voltaren Gel (diclofenac sodium topical gel)?** *(If yes, complete Section D above)*
QUANTITY LIMIT REQUESTS	
□ **Yes** □ **No**	**Does the physician attest that a larger quantity is needed for treatment of a larger surface area?**

Provider Signature: _____ **Date:** _____