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 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 at least TWO preferred non-steroidal anti-inflammatory drugs (NSAIDs), one of which must be celecoxib (generic for Celebrex)?** *(If yes, complete Section D above/MEDICAL RECORDS MUST BE SUBMITTED)* *An inadequate response to treatment is defined as pain and/or inflammatory symptoms not resolved after 14 days of therapy
	DICLOFENAC EPOLAMINE PATCH/FLECTOR PATCH
□ **Yes** □ **No**	**Does the patient have a diagnosis of acute pain due to minor strains, sprains, or contusions?**
□ **Yes** □ **No**	**Does the patient have <u>failure</u> to any of the following?** *(If yes, check which applies and complete Section D above/MEDICAL RECORDS MUST BE SUBMITTED)* □ Diclofenac topical gel 1% [Rx (prescription) formulation] □ Diclofenac topical gel 1% [OTC (over-the-counter) formulation]
□ **Yes** □ **No**	**Does the patient have a history of <u>intolerance or contraindication</u> to any of the following?** *(If yes, check which applies and complete Section D above, including the intolerance or contraindication)* □ Diclofenac topical gel 1% (Rx formulation) □ Diclofenac topical gel 1% (OTC formulation)
	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 <u>failure</u> to any of the following?** *(If yes, check which applies and complete Section D above/MEDICAL RECORDS MUST BE SUBMITTED)* □ Diclofenac topical gel 1% (Rx formulation) (generic for Voltaren) □ Diclofenac topical gel 1% (OTC formulation) (generic for Voltaren)
□ **Yes** □ **No**	**Does the patient have a history of <u>intolerance or contraindication</u> to any of the following?** *(If yes, check which applies and complete Section D above, including the intolerance or contraindication)* □ Diclofenac topical gel 1% (Rx formulation) (generic for Voltaren) □ Diclofenac topical gel 1% (OTC formulation) (generic for Voltaren)
	PENNSAID/DICLOFENAC 2% SOLUTION
□ **Yes** □ **No**	**Does the patient have a diagnosis of pain due to osteoarthritis of the knee(s)?**
□ **Yes** □ **No**	**Does the patient have <u>failure</u> to any of the following?** *(If yes, check which applies and complete Section D above/MEDICAL RECORDS MUST BE SUBMITTED)* □ Diclofenac topical gel 1% [Rx (prescription) or OTC (over the counter) formulation] (generic for Voltaren) □ Diclofenac 1.5% topical solution
□ **Yes** □ **No**	**Does the patient have a history of <u>intolerance or contraindication</u> to any of the following?** *(If yes, check which applies and complete Section D above, including the intolerance or contraindication)* □ Diclofenac topical gel 1% (Rx or OTC formulation) (generic for Voltaren) □ Diclofenac 1.5% topical solution
	VOLTAREN RX (PRESCRIPTION)
□ **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?**
□ **Yes** □ **No**	**Does the patient have <u>failure</u> to any of the following?** *(If yes, check which applies and complete Section D above/MEDICAL RECORDS MUST BE SUBMITTED)* □ Diclofenac topical gel 1% [Rx or OTC (over-the-counter) formulation] (generic Voltaren) □ Brand Voltaren topical gel 1% (OTC formulation)
□ **Yes** □ **No**	**Does the patient have a history of <u>intolerance or contraindication</u> to any of the following?** *(If yes, check which applies and complete Section D above, including the intolerance or contraindication)* □ Diclofenac topical gel 1% (Rx or OTC formulation) (generic Voltaren) □ Brand Voltaren topical gel 1% (OTC formulation)

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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?**
□ Yes □ No	**Does the patient have <u>failure</u> to any of the following?** *(If yes, check which applies and complete Section D above/MEDICAL RECORDS MUST BE SUBMITTED)* □ Diclofenac topical gel 1% (Rx formulation) (generic Voltaren) □ Diclofenac topical gel 1% (OTC formulation) (generic Voltaren)
□ Yes □ No	**Does the patient have a history of <u>intolerance or contraindication</u> to any of the following?** *(If yes, check which applies and complete Section D above, including the intolerance or contraindication)* □ Diclofenac topical gel 1% (Rx formulation) (generic Voltaren) □ Diclofenac topical gel 1% (OTC formulation) (generic Voltaren)

Provider Signature: _____ **Date:** _____