SENTARA COMMUNITY PLAN
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Topical Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)
(Non-Preferred)

PREFERRED DRUGS		
❑ **diclofenac sodium 1% gel**		
Non-Preferred Drugs		
❑ **diclofenac 1.5% topical soln**	❑ **diclofenac 2% topical soln gel**	❑ **diclofenac epolamine 1.3% patch (QL)** (30 patches per RX)
❑ **diclofenac 3% gel**	❑ **Diclogen Kit**	❑ **Flector® patch (QL)** (30 patches per RX)
❑ **Licart™ patch (QL)** (30 patches per RX)	❑ **Lixofen 1.5% Kit**	❑ **Pennsaid® top soln, soln pkt & pump**
❑ **Voltaren® 1% gel**	❑ **Xrylix™ Kit**	

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Authorization Approval Length: One (1) year

- ❑ Flector®, diclofenac epolamine 1.3% patch, diclofenac 1.5% and 2% topical solution, Licart™ patch, Lixofen 1.5% Kit, Pennsaid®, & Xrylix™ Kit
  - ❑ Member has a trial and failure to diclofenac 1% gel
  - ❑ Member has a failure to the oral generic of the desired drug AND at least one other **Preferred** NSAID (to equal a total of at least **two (2) Preferred**). **(Example: member who failed ibuprofen or naproxen will still need to try oral diclofenac for approval of Flector®.)**
- ❑ diclofenac 1.5% topical solution, diclofenac 2% topical solution, Lixofen 1.5% Kit, Pennsaid® and Xrylix™ Kit
  - ❑ Member has a diagnosis of osteoarthritis of the knee
  - ❑ Member has a failure to diclofenac sodium 1% gel
  - ❑ Member has a failure to the oral generic of the desired drug AND at least one other **Preferred** NSAID (to equal a total of at least **two (2) Preferred).** **(Example: member who failed ibuprofen or naproxen will still need to try oral diclofenac for approval of Pennsaid®.)**
- ❑ diclofenac 3% gel
  - ❑ Member has a diagnosis of actinic keratosis

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.*

REVISED/UPDATED/REFORMATTED: ~~7/6/2017~~; ~~9/1/2017~~; ~~8/31/2018~~; ~~(Rev) 4/7/2019; 6/30/2021~~ ~~11/15/2023; 1/18/2024~~, ~~9/18/2025,~~ **10/20/2025**