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 (OTC)** ❑ **diclofenac sodium 1% gel**		
Non-Preferred Drugs		
❑ **diclofenac sodium 3% gel**	❑ **Flector® patch (QL)** (30 patches per Rx)	❑ **Licart™ patch (QL)** (30 patches per Rx)
❑ **Pennsaid® topical soln, soln pkt & pump**	❑ **diclofenac 2% topical solution**	❑ **Solaraze® 3% topical gel**
❑ **Voltaren® 1% gel** (diclofenac sodium gel)	❑ **Voltaren® 1% gel** (diclofenac sodium gel) **OTC**	❑ **Vopac™ MDS**
❑ **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:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

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

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

Weight: _____ **Date:** _____

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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®, Pennsaid®, diclofenac 2% topical solution, Vopac MDS, & Xrylix™ Kit
  - Approval is based on member failing 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 2% topical solution, Pennsaid®, Vopac MDS, and Xrylix™ Kit can **only** be approved for the FDA-approved indication of osteoarthritis of the knee.
- ❑ Solaraze® 3% and diclofenac sodium 3%
  - Approved **only** for the topical treatment 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**