SENTARA HEALTH PLANS

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 information provided is not complete, correct, or legible, authorization may be delayed.**

Drug Requested: Flector® Patch (diclofenac epolamine 1.3%)

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:** _____

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.

- ❑ Member tried and failed **two (2)** of the following:
  - ❑ diclofenac 1% gel (Voltaren® Gel)

    OR
  - ❑ diclofenac 1.5% solution (Pennsaid® 1.5%)

    OR
  - ❑ Member tried and failed **four (4) NSAIDs** from the Optima Preferred Drug List **(Check all tried)**

❑ diclofenac sodium	❑ diflunisal	❑ etodolac
❑ fenoprofen	❑ flurbiprofen	❑ ibuprofen
❑ indomethacin, SR	❑ ketoprofen, SR	❑ ketorolac
❑ meclofenamate	❑ nabumetone	❑ naproxen
❑ naproxen sodium	❑ oxaprozin	❑ piroxicam
❑ sulindac	❑ tolmetin	❑ meloxicam

Not all drugs may be covered under every Plan.
If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

*****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.****

***Approved by Pharmacy and Therapeutics Committee: 2/19/2015**
REVISED/UPDATED/REFORMATTED: ~~11/28/2017; 3/1/2018; (Reformatted) 6/11/2019;~~ **1/22/2020**