

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: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

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

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 must meet **BOTH** of the following (verified by chart notes and/or pharmacy paid claims):

Member has tried and failed diclofenac 1% gel (generic Voltaren® Gel)

Member has tried and failed at least **four (4)** NSAIDs (check all that apply)

<input type="checkbox"/> diclofenac sodium	<input type="checkbox"/> diflunisal	<input type="checkbox"/> etodolac
<input type="checkbox"/> fenoprofen	<input type="checkbox"/> flurbiprofen	<input type="checkbox"/> ibuprofen
<input type="checkbox"/> indomethacin, SR	<input type="checkbox"/> ketoprofen, SR	<input type="checkbox"/> ketorolac
<input type="checkbox"/> meclofenamate	<input type="checkbox"/> nabumetone	<input type="checkbox"/> naproxen
<input type="checkbox"/> naproxen sodium	<input type="checkbox"/> oxaprozin	<input type="checkbox"/> piroxicam
<input type="checkbox"/> sulindac	<input type="checkbox"/> tolmetin	<input type="checkbox"/> 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.