UnitedHealthcare
Community Plan

TOPICAL NSAID PRIOR AUTHORIZATION REQUEST

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date:

SECTION A - PATIENT INFORMATION

First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW □ or a CONTINUATION of THERAPY□? If so, start date:______________
Is this patient currently hospitalized? □Yes □No

SECTION B - PHYSICIAN INFORMATION

First Name:		Last Name:		
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

SECTION C - MEDICAL INFORMATION

Medication:		**Strength:**
Directions for use:		
Diagnosis:	**ICD-10 CODE:**	**Frequency of Administration:**

Did the patient have inadequate pain relief when treated with at least <u>three</u> formulary non-steroidal anti-inflammatory drugs (NSAIDs) in the previous three months? (An inadequate response is defined as pain and/or inflammatory symptoms not resolved after 14 days) Yes____ No___

Does the patient have <u>one</u> of the following risk factors?
Patient is 60 years of age or greater Yes____ No___
Patient has a previous clinical history of gastrointestinal (GI) ulcer, GI bleeding, or GI perforation Yes____ No___
Patient is also taking chronic systemic corticosteroids (e.g. prednisone), anticoagulants (e.g. Coumadin, Warfarin, Jantoven, Lovenox, Fragmin, Arixtra, Heparin) or anti-platelet agents (excluding aspirin) (e.g. Plavix, Aggrenox, Effient, ticlopidine, cilostazol) Yes____ No___

If the <u>Flector</u> patch is the requested medication, does the patient have a diagnosis of acute pain due to minor sprains, strains, or contusions? Yes____ No___

If <u>Voltaren Gel</u> is the requested medication, does the patient have a diagnosis of osteoarthritis of the hands and/or knees? Yes____ No___

If <u>Pennsaid</u> is the requested medication, does the patient have a diagnosis of osteoarthritis of the knees? Yes____ No___

Physician Signature: ____ **Date:** _______________

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