Please Note: Medical Necessity Prior Authorization may be overrided for both formulary coverage and benefit design restrictions. They are issued at the full discretion of the benefit manager.

PRIOR AUTHORIZATION **BYPASS**

Flector® (diclofenac epolamine patch)

Bypass the Prior Authorization by Modifying the following Prescription Forms to the Patient's Needs

Name _____

Address _____

℞

MD _____

Signature _____

Name _____

Address _____

℞ *Aompound 3%*
diclofenac topical cream
quantity #120gm
sig: apply 3 x per day

as directed by physician

Dx: MUSCLE PAIN

ICD 10: M 79.7

MD _____

Signature _____

Prescriber Information

Last Name:	First Name
DEA/NPI:	Specialty:
Phone	Fax

Member Information

Last Name:	First Name
Member ID Number	DOB:

Medication Information:

Drug Name and Strength:	Quantity and Dosing:
Diagnosis:	Duration:

When advised below, please include all requested fax documentation (lab results, etc.) when submitting this Prior Authorization fax form; not submitting requested documentation could delay the clinical review process.

Flector (diclofenac epolamine patch 1.3%)
Prior Authorization Form

You must answer ALL of the following questions		
1. Is the patient 18 years of age or older?	Y	N
2. Does the patient have a diagnosis of acute, localized pain due to minor strains, sprains or contusions? *Please provide chart notes to corroborate*.	Y	N
3. Has the patient had the pain for less than or equal to 3 months?	Y	N
4. Is the patient high risk, as defined by at least one of the following conditions? **(If yes, please circle.)** • The patient has a history of ulcers • History of upper gastrointestinal bleeding requiring hospitalization and/or blood transfusion • History of serious bleeding disorder • Current treatment with anticoagulants such as warfarin, a low molecular weight heparin (LMWH) such as enoxaparin (Lovenox), Fragmin, a direct factor XA inhibitor such as Arixtra, Xarelto, or heparin • The patient is currently taking oral corticosteroids • The patient is receiving or has recently received chemotherapy • The patient is 65 years of age or older • The patient has a history of renal disease • The patient has received gastric bypass surgery	Y	N

5. Has the patient tried and failed at least two (2) prior non-steroidal anti-inflammatory drugs (NSAIDs)? *Please list which NSAIDS have been tried*_____	Y	N
6. Is the patient unable to swallow oral medications?	Y	N
7. Is the patient currently taking any other oral tablets or capsules (not including: orally dissolving tablets and sprinkle capsules)?	Y	N

Please note, not all drugs/diagnoses are covered on all plans.

Comments: _____

Information given on this form is accurate as of this date.

Prior Authorization forms are located on the Cover Page. Print a new form for each request as forms are updated periodically.

_____ _____

Prescriber or Authorized Signature **Date**

_____

Authorized Medical Staff – Name/Title

Attention Healthcare Provider: If you would like to discuss this request with a medical professional, please contact the Prior Authorization Departmentt whose numbers appear on the Cover Page.

I understand that USDoctor's use or disclosure of individually identifiable health information, whether furnished by me or obtained by another source such as medical providers, shall be in accordance with federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

Contact Information:

Telephone: (855)251.9116
Fax: (248)593.9575

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PRIOR AUTHORIZATION FORM:
COVER PAGE

MEMBER INFORMATION			
First Name		**Last Name**	
Plan			
Member ID		**Date of Birth**	

DRUG INFORMATION			
Drug Name			
Quantity		**ICD-10**	
Directions		**Duration of Therapy**	
Diagnosis			

PLEASE LIST ALTERNATIVE THERAPIES THAT HAVE BEEN ATTEMPTED AND ANY OTHER PERTINENT INFORMATION RELATED TO DRUG AND/OR DISEASE STATE. IF NOT PRESENT, WITHIN NORMAL LIMITS WILL BE USED FOR THE REVIEW.

Medication/Failure Reason:

IgE:_____

ESR:_____ **CRP:**_____ **# Joints:**_____ **%BSA:**_____

Height:_____ **Weight:**_____ **BMI:**_____

HA1C:_____ **Hemoglobin:**_____ **Hematocrit:**_____ **T-Score:**_____

Dialysis:_____ **Long Term Care Facility:**_____ **Self Injecting:**_____

Stimulation test:_____/_____ **Growth velocity:**_____ **#Chemotherapy cycles/month:**_____

Mini-Mental Status Test:_____ **Baseline Free testosterone/Total testosterone:**_____/_____

HCV RNA viral load:_____ **Viral Genotype:**_____ **ALT:**_____

PHYSICIAN INFORMATION			
Physician Signature		**Date**	
Physician Name		**NPI #**	
Phone Number		**Fax Number**	
Action Needed	Only mark Urgent when standard review time would seriously harm the member's life or health or ability to regain maximum function ☐ Urgent ☐ For Review	**Pharmacy Fax**	