



This form is based on Express Scripts standard criteria and may not be applicable to all patients; certain plans and situations may require additional information beyond what is specifically requested.

Additional forms available: www.express-scripts.com/pa

Fax completed form to **1-800-357-9577**

If this an **URGENT** request, please call 1-800-417-8164

Patient Information

Patient First Name: _____

Patient Last Name: _____

Patient ID#: _____

Patient DOB: _____

Patient Phone #: _____

Prescriber Information

Prescriber Name: _____

Prescriber DEA/NPI (required): _____

Prescriber Phone #: _____

Prescriber Fax #: _____

Prescriber Address: _____

State: _____ Zip Code: _____

Primary Diagnosis: _____ ICD Code: _____

Please indicate which drug and strength is being requested:

- | | | |
|--|--|--|
| <input type="checkbox"/> Anaprox 275mg | <input type="checkbox"/> Lodine 300mg | <input type="checkbox"/> Orudis 25mg |
| <input type="checkbox"/> Anaprox DS 550mg | <input type="checkbox"/> Lodine 400mg | <input type="checkbox"/> Orudis 50mg |
| <input type="checkbox"/> Ansaid 50mg | <input type="checkbox"/> Lodine 500mg | <input type="checkbox"/> Orudis 75mg |
| <input type="checkbox"/> Ansaid 100mg | <input type="checkbox"/> Lodine XL 400mg | <input type="checkbox"/> Oruvail 100mg |
| <input type="checkbox"/> Arthrotec 50 | <input type="checkbox"/> Lodine XL 500mg | <input type="checkbox"/> Oruvail 150mg |
| <input type="checkbox"/> Arthrotec 75 | <input type="checkbox"/> Lodine XL 600mg | <input type="checkbox"/> Oruvail 200mg |
| <input type="checkbox"/> Cambia Powder | <input type="checkbox"/> Mobic 7.5mg | <input type="checkbox"/> Pennsaid 1.5% Topical Solution |
| <input type="checkbox"/> Cataflam 50mg | <input type="checkbox"/> Mobic 15mg | <input type="checkbox"/> Ponstel 250mg |
| <input type="checkbox"/> Clinoril 150mg | <input type="checkbox"/> Mobic 7.5mg/5ml Suspension | <input type="checkbox"/> Prevacid Naprapac 375mg |
| <input type="checkbox"/> Clinoril 200mg | <input type="checkbox"/> Motrin 100mg/5ml Suspension | <input type="checkbox"/> Prevacid Naprapac 500mg |
| <input type="checkbox"/> Daypro 600mg | <input type="checkbox"/> Motrin 200mg | <input type="checkbox"/> Relafen 500mg |
| <input type="checkbox"/> Daypro ALTA 600mg | <input type="checkbox"/> Motrin 400mg | <input type="checkbox"/> Relafen 750mg |
| <input type="checkbox"/> EC-Naprosyn 375mg | <input type="checkbox"/> Motrin 600mg | <input type="checkbox"/> Sprix 15.75mg/actuation Nasal Spray |
| <input type="checkbox"/> EC-Naprosyn 500mg | <input type="checkbox"/> Motrin 800mg | <input type="checkbox"/> Toradol 15mg/ml Injection |
| <input type="checkbox"/> Feldene 10mg | <input type="checkbox"/> Nalfon 200mg | <input type="checkbox"/> Toradol 30mg/ml Injection |
| <input type="checkbox"/> Feldene 20mg | <input type="checkbox"/> Nalfon 300mg | <input type="checkbox"/> Toradol 10mg Tablet |
| <input type="checkbox"/> Flector 1.3% Topical Patch | <input type="checkbox"/> Nalfon 400mg | <input type="checkbox"/> Vimovo 375mg-20mg Delayed Release Tab |
| <input type="checkbox"/> IC400 Kit | <input type="checkbox"/> Naprelan 375mg | <input type="checkbox"/> Vimovo 500mg-20mg Delayed Release Tab |
| <input type="checkbox"/> IC800 Kit | <input type="checkbox"/> Naprelan 500mg | <input type="checkbox"/> Voltaren 1% Topical Gel |
| <input type="checkbox"/> Indocin 25mg | <input type="checkbox"/> Naprelan 750mg | <input type="checkbox"/> Voltaren 25mg Tablet |
| <input type="checkbox"/> Indocin 50mg | <input type="checkbox"/> Naprelan CR Dose Card | <input type="checkbox"/> Voltaren 50mg Tablet |
| <input type="checkbox"/> Indocin 25mg/5ml Suspension | <input type="checkbox"/> Naprosyn 250mg | <input type="checkbox"/> Voltaren 75mg Tablet |
| <input type="checkbox"/> Indocin SR 75mg | <input type="checkbox"/> Naprosyn 375mg | <input type="checkbox"/> Voltaren-XR 100mg Tablet |
| <input type="checkbox"/> Lodine 200mg | <input type="checkbox"/> Naprosyn 500mg | <input type="checkbox"/> Zipsor 25mg |
| | | <input type="checkbox"/> Other: _____ |

Directions for use (i.e. QD, BID, PRN & Qty): _____

Please complete the clinical assessment:

1. Is the patient currently taking the requested medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
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<p>2. Is the patient taking samples or paying 100% out of pocket for the medication being requested?</p> <p>If no, please indicate:</p> <p><input type="checkbox"/> Requested medication covered under previous insurance plan</p> <p><input type="checkbox"/> Started medication in hospital</p> <p><input type="checkbox"/> Other: _____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<p>3. Has the patient tried <u>two</u> unique <u>prescription-strength generic</u> NSAIDs for the current condition?</p> <p>If yes, please provide names, strengths and directions: _____</p> <p>_____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<p>4. <u>If prescribing Flector Patch, Sprix, Pennsaid, or Voltaren Gel only</u>, is the patient unable to or has difficulty swallowing?</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<p>5. <u>If prescribing Pennsaid or Voltaren Gel only</u>, does the patient have a chronic musculoskeletal pain condition (e.g., osteoarthritis)?</p> <p>If yes, please document: _____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A
<p>6. <u>If prescribing Pennsaid or Voltaren Gel only</u>, how many joints or sites are affected?</p> <p>Please list: _____</p>			
<p>7. <u>If prescribing Pennsaid or Voltaren Gel only</u>, is the patient at risk of NSAID-associated toxicity?</p> <p>If yes, what NSAID associated toxicity is the patient at risk for? _____</p> <p>_____</p>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A

Are there any other comments, diagnoses, symptoms, and/or any other information the physician feels is important to this review?

Prescriber Signature: _____	Date: _____
Office Contact Name: _____ Phone Number: _____	

Based upon each patient's prescription plan, additional questions may be required to complete the prior authorization process. If you have any questions about the process or required information, please contact our prior authorization team at the number listed on the top of this form.

Prior Authorization of Benefits is not the practice of medicine or a substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for the patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions.

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