**Analgesic Agents: NSAIDS**

|  |  |
| --- | --- |
| Criteria 1 | NP - Diclofenac/Misoprostol, Diclofenac Gel 3%, Diclofenac Patch 1.3%, Diclotrex, Elyxyb, Fenoprofen 400mg, Ibuprofen/Famotidine, Ketorolac Tromethamine Nasal Spray, Ketoprofen, Licart Patch, Meloxicam Cap, Naproxen CR, Naproxen DR, Naproxen ER, Naproxen EC, Naproxen/Esomeprazole, Qmiiz ODT, Relafen DS, Zorvolex |
| Criteria 2 | NP- Pennsaid (NP, BvG), Diclofenac Soln |
| Criteria 3 | Naproxen Susp (P, AR) |

|  |  |  |  |
| --- | --- | --- | --- |
| **Criteria Title** | Analgesic Agents: NSAIDS | | |
| **Criteria Subtitle** | Non-Preferred Products | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| DICLOFENAC/MISOPROSTOL | 020279 | GCNSeqNo |
| DICLOFENAC/MISOPROSTOL | 035737 | GCNSeqNo |
| DICLOFENAC GEL 3% | 039826 | GCNSeqNo |
| DICLOFENAC PATCH 1.3% | 062176 | GCNSeqNo |
| DICLOFENAC SOLN 1.5% | 051971 | GCNSeqNo |
| DICLOFENAC POTASSIUM | 021380 | GCNSeqNo |
| DICLOTREX | 081406 | GCNSeqNo |
| ELYXYB | 081009 | GCNSeqNo |
| FENOPROFEN 400 mg | 065880 | GCNSeqNo |
| IBUPROFEN/FAMOTIDINE | 067901 | GCNSeqNo |
| KETOROLAC TROMETHAMINE NASAL SPRAY | 067386 | GCNSeqNo |
| KETOPROFEN | 008379 | GCNSeqNo |
| KETOPROFEN | 008380 | GCNSeqNo |
| LICART PATCH | 079402 | GCNSeqNo |
| MELOXICAM CAP | 075207 | GCNSeqNo |
| MELOXICAM CAP | 075208 | GCNSeqNo |
| NAPROXEN CR, DR, ER, EC | 018435 | GCNSeqNo |
| NAPROXEN CR, DR, ER, EC | 018436 | GCNSeqNo |
| NAPROXEN CR, DR, ER, EC | 044257 | GCNSeqNo |
| NAPROXEN CR, DR, ER, EC | 063142 | GCNSeqNo |
| NAPROXEN CR, DR, ER, EC | 064693 | GCNSeqNo |
| NAPROXEN/ESOMEPRAZOLE | 066328 | GCNSeqNo |
| NAPROXEN/ESOMEPRAZOLE | 066329 | GCNSeqNo |
| OMIIZ ODT | 073318 | GCNSeqNo |
| OMIIZ ODT | 079274 | GCNSeqNo |
| RELAFEN DS | 041308 | GCNSeqNo |
| ZORVOLEX | 071599 | GCNSeqNo |
| ZORVOLEX | 071600 | GCNSeqNo |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0998 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1233 |
| 2 | 0999 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1000 |
| N | 1235 |
| 3 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days with at least two preferred drugs?  If yes, please submit the medication trials and dates. | Y | 1002 |
| N | 1001 |
| 4 | 1001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1002 |
| N | 1236 |
| 5 | 1002 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1003 |
| N | 1004 |
| 6 | 1003 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e., medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | 1004 |
| N | 1235 |
| 7 | 1004 |  | Select | What is the patient’s diagnosis? | H. Pylori Treatment | END (Approve x 30 Days) |
| Transdermal/Topical | END (Approve x 90 Days) |
| Other | END (Approve x 365 Days) |
| 8 | 1233 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | 1234 |
| N | 1235 |
| 9 | 1234 |  | Select | What is the patient’s diagnosis? | H. Pylori Treatment | END (Approve x 30 Days) |
| Transdermal/Topical | END (Approve x 90 Days) |
| Other | END (Approve x 365 days) |
| 10 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 11 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: H. Pylori Treatment 30 days, Transdermal/Topical 90 days, All Other Treatments 365 days

|  |  |
| --- | --- |
| **Last Approved** | 8/22/2023 |
| **Other** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Criteria Title** | Analgesic Agents: NSAIDs | | |
| **Criteria Subtitle** | Pennsaid | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred |  | | Non-Preferred | X | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| PENNSAID | 071910 | GCNSeqNo |
| DICLOFENAC SOLN | 071910 | GCNSeqNo |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 0998 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 0999 |
| Continuation (re-authorization request) | 1233 |
| 2 | 0999 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1000 |
| N | 1235 |
| 3 | 1000 |  | Select and Free Text | Has the patient had an inadequate clinical response of at least 30 days with at least two preferred drugs?  If yes, please submit the medication trials and dates. | Y | 1002 |
| N | 1001 |
| 4 | 1001 |  | Select and Free Text | Has the provider submitted documentation of medical necessity beyond convenience for why the patient cannot be changed to a preferred drug (i.e., allergies, drug-drug interactions, contraindications, or intolerances)?  If yes, please submit the medication name and reason for inability to use. | Y | 1002 |
| N | 1236 |
| 5 | 1002 |  | Select | Is the request for any of the following:  1) a nonsolid oral dosage formulation  2) a non-preferred extended release formulation  3) a non-preferred brand name that has a preferred generic product | Y | 1003 |
| N | 1004 |
| 6 | 1003 |  | Select and Free Text | Has the provider submitted documentation of medical necessity for the requested product (i.e. medical reasons for why the patient cannot be changed to a solid oral dosage formulation, inadequate clinical response with a product’s immediate release formulation, or inadequate clinical response or allergy of two or more generic labelers)? | Y | 1004 |
| N | 1235 |
| 7 | 1004 |  | Select | Is the request for any of the following agents: Brand Pennsaid, generic diclofenac soln? | Y | 1005 |
| N | 1007 |
| 8 | 1005 |  | Select | Which medication is being requested? | Brand Pennsaid | 1007 |
| Generic diclofenac soln | 1006 |
| Other | 1235 |
| 9 | 1006 |  | Select and Free Text | Has the brand medication been attempted and failed or is the brand medication contraindicated?  If yes, please submit documentation. | Y | 1007 |
| N | 1235 |
| 10 | 1007 |  | Select | What is the patient’s diagnosis? | H. Pylori Treatment | END (Approve x 30 Days) |
| Transdermal/Topical | END (Approve x 90 Days) |
| Other | END (Approve x 365 Days) |
| 11 | 1233 |  | Select and Free Text | Has the provider submitted documentation of the patient’s clinical response to treatment and ongoing safety monitoring? | Y | 1234 |
| N | 1235 |
| 12 | 1234 |  | Select | What is the patient’s diagnosis? | H. Pylori Treatment | END (Approve x 30 Days) |
| Transdermal/Topical | END (Approve x 90 Days) |
| Other | END (Approve x 365 Days) |
| 13 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 14 | 1236 |  | Free Text | Please explain the reason(s) why the patient is unable to use medications not requiring prior approval. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: H. Pylori Treatment 30 days, Transdermal/Topical 90 days, All Other Treatments 365 days

|  |  |
| --- | --- |
| **Last Approved** | 8/22/2023 |
| **Other** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Criteria Title** | Analgesic Agents: NSAIDs | | |
| **Criteria Subtitle** | Naproxen Susp | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**   |  |  | | --- | --- | | Preferred | X | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| NAPROXEN SUSP | 008359 | GCNSeqNo |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 1234 |  | Select | Is the patient 12 years old and older?  Please note: a PA is only required for patients 12 years old and older. | Y | 1235 |
| N | 1236 |
| 2 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |
| 3 | 1236 |  | Free Text | A PA is not required for those younger than 12 years of age. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: H. Pylori Treatment 30 days, Transdermal/Topical 90 days, All Other Treatments 365 days

|  |  |
| --- | --- |
| **Last Approved** | 8/22/2023 |
| **Other** |  |