EXPRESS SCRIPTS®

Prior Authorization Form
Brand NSAID Step Therapy

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 **1-877-329-3760**
If this an **URGENT** request, please **call** 1-800-753-2851

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:

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

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

Please complete the clinical assessment:			
1. Is the patient currently taking the requested medication?	☐ Yes	☐ No	☐ N/A

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