Please complete ALL information below and fax your request to 1-888-671-5285

Diclofenac sodium 3% gel Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:

❑ Actinic keratosis

❑ Other diagnosis: ______________________________ ICD-10 Code(s): ________________________________

Medication history:

Does the patient have a trial and failure, intolerance, or contraindication to generic fluorouracil or generic imiquimod? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per MONTH? _______

What is the reason for exceeding the plan limitations?

❑ Patient requires a greater quantity for the treatment of a larger surface area

❑ Other: ____

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

____

____

Please note: This request may be denied unless all required information is received.

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