Prior Authorization of Benefits Form

CONTAINS CONFIDENTIAL PATIENT INFORMATION
Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 844-512-9004.
Provider Help Desk: 800-454-3730

1. Patient information	**2. Physician information**
Patient name: _____	Prescribing physician: _____
Patient ID #: _____	Physician address: _____
Patient DOB: _____	Physician phone #:_____
Date of Rx: _____	Physician fax #: _____
Patient phone #: _____	Physician specialty: _____
Patient email address: _____	Physician DEA: _____
	Physician NPI #: _____
	Physician email address: _____

3. Medication	**4. Strength**	**5. Directions**	**6. Quantity per 30 days**
_____	_____	_____	Specify: _____

7. Diagnosis: _____

8. Approval criteria: (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

1. Prior authorization (PA) is required for all nonpreferred, nonsteroidal anti-inflammatory drugs (NSAIDs) and COX-2 inhibitors. PA is not required for preferred NSAIDs or COX-2 inhibitors.Requests for a nonpreferred NSAID must document previous trials and therapy failures with at least three preferred NSAIDs.
2. Requests for a nonpreferred COX-2 inhibitor must document previous trials and therapy failures with three preferred NSAIDs, two of which must be preferred COX-2 preferentially selective NSAIDs.
3. Requests for a nonpreferred extended release NSAID must document previous trials and therapy failures with three preferred NSAIDs, one of which must be the preferred immediate release NSAID of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance.

The required trials be can overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred (no PA required)		**Nonpreferred (PA required)**		
☐ Celecoxib	☐ Meloxicam (COX-2)	☐ Arthrotec	☐ Flector Patch	☐ Piroxicam
☐ Diclofenac Sod./Pot.	☐ Nabumetone (COX-2)	☐ Celebrex	☐ Indomethacin ER*	☐ Qmiiz ODT
		☐ Ketoprofen ER		☐ Vivlodex
☐ Diclofenac Sod.	☐ Naproxen EC/ER	☐ Diclofenac ER/XR*	☐ Tivorbex	☐ Zipsor

EC/DR
☐ Etodolac 400mg/500mg
☐ Flurbiprofen
☐ Ibuprofen
☐ Ibuprofen Susp.
☐ Indomethacin
☐ Ketoprofen
☐ Naproxen Sod 550mg
☐ Naproxen Tab
☐ Salsalate
☐ Sulindac
☐ Voltaren Gel
☐ Diclofenac Epolamine
☐ EC-Naprosyn
☐ Etodolac CR/ER/XR
☐ Fenoprofen
☐ Other (specify): _____
☐ Meclofenamate Sod
☐ Naprelan
☐ Naproxen Susp
☐ Oxaprosin
☐ Pennisaid
☐ Zorvolex
☐ Tolmetin Sod

Diagnosis: _____

Preferred drug trial #1 drug name and dose: _____ Trial dates:_____

Failure reason: _____

Preferred drug trial #2 drug name and dose: _____ Trial dates: _____

Failure reason: _____

Preferred drug trial #3 drug name and dose: _____ Trial dates: _____

Failure reason: _____

Medical necessity for alternative delivery system: _____

Medical or contraindication reason to override trial requirements: _____

Reason for use of Nonpreferred drug requiring prior approval: _____

Attach lab results and other documentation as necessary.

9. Physician signature

_____ _____

Prescriber or authorized signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.
Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Important note*: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*