

**Licart (diclofenac epolamine 1.3%)
Prior Authorization Request Form**

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

URGENT

| MEMBER INFORMATION | | |
|------------------------------|----------------|-----------|
| LAST NAME: | FIRST NAME: | |
| PHONE NUMBER: | DATE OF BIRTH: | |
| STREET ADDRESS: | | |
| CITY: | STATE: | ZIP CODE: |
| PATIENT INSURANCE ID NUMBER: | | |

MALE FEMALE HEIGHT (IN/CM): _____ WEIGHT (LB/KG): _____ ALLERGIES: _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____

AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

| PRESCRIBER INFORMATION | |
|---|------------------------|
| LAST NAME: | FIRST NAME: |
| PRESCRIBER SPECIALTY: | EMAIL ADDRESS: |
| NPI NUMBER: | DEA NUMBER: |
| PHONE NUMBER: | FAX NUMBER: |
| STREET ADDRESS: | |
| CITY: | STATE: ZIP CODE: |
| REQUESTOR (if different than prescriber): | OFFICE CONTACT PERSON: |

| MEDICATION OR MEDICAL DISPENSING INFORMATION | | | |
|--|----------------------------------|-------------------------------------|-----------|
| MEDICATION NAME: | | | |
| DOSE/STRENGTH: | FREQUENCY: | LENGTH OF THERAPY/REFILLS: | QUANTITY: |
| <input type="checkbox"/> NEW THERAPY | <input type="checkbox"/> RENEWAL | IF RENEWAL: DATE THERAPY INITIATED: | |
| DURATION OF THERAPY (SPECIFIC DATES): | | | |

Continued on next page.

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MEMBER'S LAST NAME: _____ MEMBER'S FIRST NAME: _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? YES (if yes, complete below) NO

| MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE): | DURATION OF THERAPY (SPECIFY DATES): | RESPONSE/REASON FOR FAILURE/ALLERGY: |
|--|--------------------------------------|--------------------------------------|
| | | |

2. LIST DIAGNOSES: **ICD-10:**

| | |
|---|--|
| <input type="checkbox"/> Acute, localized pain due to minor strains, sprains or contusions <i>Please provide chart notes to corroborate.</i> | |
| <input type="checkbox"/> Other diagnosis: _____ ICD-10: _____ | |

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Has the patient had the pain for less than or equal to 3 months? Yes No

Is the patient high risk, as defined by at least one of the following conditions? Yes No

If **yes**, please select:

- Current treatment with anticoagulants such as warfarin, a low molecular weight heparin (LMWH) such as enoxaparin (Lovenox), Fragmin, a direct factor XA inhibitor such as Arixtra, Xarelto, or heparin
- Currently taking oral cortico
- History of a serious bleeding disorder
- History of renal disease
- History of ulcers
- History of upper gastrointestinal bleeding requiring hospitalization and/or blood transfusion
- Received gastric bypass surgery
- Receiving or has recently received chemotherapy
- 65 years of age or older

Has the patient tried and failed at least two (2) prior non-steroidal anti-inflammatory drugs (NSAIDs)? Yes No

Please list which NSAIDs have been tried: _____

Is the patient unable to swallow oral medications? Yes No (please provide documentation)

Is the patient currently taking any other oral tablets or capsules (not including: orally dissolving tablets and sprinkle capsules)? Yes No

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: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

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ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

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FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program

Attn: CP – 4201

P.O. Box 64811

St. Paul, MN 55164-0811