



Request for Prior Authorization
NONSTEROIDAL ANTI-INFLAMMATORY DRUGS

(PLEASE PRINT - ACCURACY IS IMPORTANT)

Form with fields for IA Medicaid Member ID #, Patient name, DOB, Patient address, Provider NPI, Prescriber name, Phone, Prescriber address, Fax, Pharmacy name, Address, Phone, Pharmacy NPI, Pharmacy fax, NDC.

Prior authorization (PA) is required for all non-preferred nonsteroidal anti-inflammatory drugs (NSAIDs). Payment for a non-preferred NSAID will be considered under the following conditions: 1. Documentation of previous trials and therapy failures with at least three preferred NSAIDs; and 2. Requests for a non-preferred 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.

Preferred (No PA required)

- Celecoxib (COX-2)
Diclofenac Sod/Pot
Diclofenac Sod. EC/DR
Etodolac 400mg/500mg
Flurbiprofen
Ibuprofen
Ibuprofen Susp
Indomethacin
Ketoprofen
Meloxicam (COX-2)
Nabumetone (COX-2)
Naproxen Tab
Naproxen EC/ER
Naproxen sod 550mg
Salsalate
Sulindac
Voltaren Gel

Non-Preferred (PA required for all products)

- Arthrotec
Celebrex
Diclofenac ER/XR*
Diclofenac Epolamine
EC-Naprosyn
Etodolac CR/ER/XR
Fenoprofen
Flector Patch
Indomethacin ER*
Ketoprofen ER
Licart
Meclofenamate Sod
Meloxicam Caps
Naprelan
Naproxen ER 750mg
Naproxen Susp
Oxaprozin
Pennsaid
Piroxicam
Qmiiiz ODT
Tivorbex
Tolmetin Sod
Vivlodex
Zipsor
Zorvolex

Other (specify)

Strength Dosage Instructions Quantity Days Supply

Diagnosis:

Preferred NSAID Trial 1: Drug Name& Dose Trial Dates:

Failure Reason

Preferred NSAID Trial 2: Drug Name& Dose Trial Dates:

Failure Reason

Preferred NSAID Trial 3: Drug Name& Dose Trial Dates:

Failure Reason

Medical Necessity for alternative delivery system:

Medical or contraindication reason to override trial requirements:

Reason for use of Non-Preferred drug requiring prior approval:

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.) Date of submission

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.