



**Request for Prior Authorization
NONSTEROIDAL ANTI-INFLAMMATORY
DRUGS**

**FAX Completed Form
To**

I (800) 574-2515

Provider Help Desk

I (877) 776-1567

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
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. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.

Preferred (No PA required)

- Celecoxib (COX-2)
- Diclofenac Sod/Pot
- Diclofenac Sod. EC/DR
- Diclofenac Sod Gel 1%
- 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

Non-Preferred (PA required for all products)

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Arthrotec | <input type="checkbox"/> Flector | <input type="checkbox"/> Oxaprozin |
| <input type="checkbox"/> Celebrex | <input type="checkbox"/> Indomethacin ER* | <input type="checkbox"/> Pennsaid |
| <input type="checkbox"/> Diclofenac ER/XR* | <input type="checkbox"/> Ketoprofen ER | <input type="checkbox"/> Piroxicam |
| <input type="checkbox"/> Diclofenac Epolamine | <input type="checkbox"/> Licart | <input type="checkbox"/> Tolmetin Sod |
| <input type="checkbox"/> Diclofenac Packet | <input type="checkbox"/> Meclofenamate Sod | <input type="checkbox"/> Vivlodex |
| <input type="checkbox"/> Diclofenac Pot Caps | <input type="checkbox"/> Meloxicam Caps | |
| <input type="checkbox"/> EC-Naprosyn | <input type="checkbox"/> Naprelan | |
| <input type="checkbox"/> Etodolac CR/ER/XR | <input type="checkbox"/> Naproxen ER 750mg | |
| <input type="checkbox"/> Fenoprofen | <input type="checkbox"/> Naproxen Susp | |

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
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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.