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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

## Arthrotec<sup>®</sup> (diclofenac-misoprostol) Prior Authorization Request Form

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

Member Information <small>(required)</small>			Provider Information <small>(required)</small>		
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 <small>(required)</small>			
Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>		Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			

Clinical Information <small>(required)</small>
<p><b>Select the diagnosis below:</b></p> <p><input type="checkbox"/> Osteoarthritis, in patients at high risk of developing non-steroidal anti-inflammatory (NSAID) induced gastric and duodenal ulcers and their complications</p> <p><input type="checkbox"/> Rheumatoid arthritis, in patients at high risk of developing NSAID-induced gastric and duodenal ulcers and their complications</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>
<p><b>Medication history:</b></p> <p>Select the medications the patient has a history of failure, contraindication, or intolerance to:</p> <p><input type="checkbox"/> Diclofenac-misoprostol</p> <p><input type="checkbox"/> Duexis</p> <p><input type="checkbox"/> Vimovo</p> <p>Does the patient have a history of failure, contraindication, or intolerance to one of the following diclofenac products [diclofenac potassium, diclofenac sodium delayed-release (DR), diclofenac sodium extended-release (ER)] used <b><i>in combination</i></b> with misoprostol? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b></p> <p>Does the patient have a history of failure, contraindication, or intolerance to an oral generic NSAID (e.g., celecoxib, diclofenac potassium, diclofenac sodium DR, diclofenac sodium ER, diflunisal, etodolac, etodolac ER, fenoprofen, flurbiprofen, ibuprofen, indomethacin, ketoprofen, ketoprofen ER, ketorolac, meclofenamate, mefenamic acid, meloxicam, nabumetone, naproxen, naproxen DR, naproxen sodium, oxaprozin, piroxicam, sulindac, tolmetin)? <input type="checkbox"/> <b>Yes</b> <input type="checkbox"/> <b>No</b></p>

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

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Please note: This request may be denied unless all required information is received.  
 If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.  
 For urgent or expedited requests please call 1-800-711-4555.  
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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 Office use only: Arthrotec-DiclofenacMisoprostol\_CMS\_2019Jan1-W