OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Flector® Prior Authorization Request Form (Page 1 of 2)

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Member Information (required)			**Provider Information** (required)		
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 (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand** ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the diagnosis below:
❑ Acute pain due to minor strain, sprain, or contusion
❑ Other diagnosis: ______________________________ ICD-10 Code(s): ______________________________

Clinical information:
Is the requested medication being used for localized pain? ❑ **Yes** ❑ **No**

Will the requested medication be used in the treatment of peri-operative pain in the setting of coronary artery bypass graft surgery or used on non-intact or damaged skin? ❑ **Yes** ❑ **No**

Does the patient have treatment failure with at least two prescription strength oral non-steroidal anti-inflammatory drugs (NSAIDs)? ❑ **Yes** ❑ **No**

Does the patient have a documented swallowing disorder? ❑ **Yes** ❑ **No**

Does the patient have history of peptic ulcer disease/gastrointestinal bleed? ❑ **Yes** ❑ **No**

Is the patient older than 65 years of age with one additional risk factor for gastrointestinal adverse events (e.g., use of anticoagulants, chronic corticosteroids)? ❑ **Yes** ❑ **No**

Does the patient have a history of severe allergic-type reactions after taking aspirin or other non-steroidal anti-inflammatory drugs (NSAIDs), including urticarial and asthma (aspirin-sensitive asthma)? ❑ **Yes** ❑ **No**

Select the medications the patient has a failure, contraindication, or intolerance to:
❑ Celecoxib
❑ Daypro
❑ Diclofenac potassium
❑ Diclofenac sodium
❑ Diclofenac sodium delayed-release (DR)
❑ Diclofenac sodium extended-release (ER)
❑ Diflunisal
❑ EC-Naprosyn
❑ Etodolac
❑ Etodolac ER
❑ Feldene
❑ Fenoprofen
❑ Flurbiprofen
❑ Ibu
❑ Ibuprofen
❑ Ketoprofen
❑ Ketoprofen ER
❑ Meclofenamate
❑ Meloxicam
❑ Mobic
❑ Nabumetone
❑ Nalfon
❑ Naproxen
❑ Naproxen DR
❑ Naproxen sodium
❑ Naproxen sodium ER
❑ Oxaprozin
❑ Piroxicam
❑ Profeno
❑ Sulindac
❑ Tolmetin
❑ Voltaren
❑ Zipsor

Quantity limit requests:
What is the quantity requested per DAY? _______
What is the reason for exceeding the plan limitations?
❑ Titration or loading-dose purposes
❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
❑ Requested strength/dose is not commercially available
❑ There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify**: ______________________________
❑ Other: ______________________________

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Flector® Prior Authorization Request Form (Page 2 of 2)

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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: 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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