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

Indomethacin, indomethacin extended-release (ER), Indocin® suspension, Tivorbex®
Prior Authorization Request Form (Page 1 of 3)

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

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

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

Clinical Information (required)

Select the diagnosis below:

❑ Acute gouty arthritis (gout) [**Indomethacin, Indocin suspension, and Tivorbex** only]
❑ Acute painful shoulder (bursitis and/or tendonitis)
❑ Other diagnosis: _____ ICD-10 Code(s): _____
❑ Ankylosing spondylitis ❑ Pain
❑ Osteoarthritis ❑ Rheumatoid arthritis

If the patient has End-Stage Renal Disease (ESRD), select all that apply:

❑ The medication is being used to treat one of the following: Graft site pain or pain medication overdose
❑ The dialysis provider (i.e., nephrologist, nurse practitioner, physician assistant, or dialysis center) receives a monthly capitation payment to manage the ESRD patient's care

The approval criteria is based on the guidance provided by the Centers for Medicare & Medicaid Services (CMS), the Pharmacy Quality Alliance, the American Geriatric Society and the National Committee for Quality Assurance (NCQA). "Use of High Risk Medications in the Elderly" is measure 238 of the Centers for Medicare & Medicaid Services Physician Quality Reporting System.

Risk acknowledgment:

Does the provider acknowledge that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population? ❑ **Yes** ❑ **No**

Does the provider wish to proceed with the originally prescribed medication? ❑ **Yes** ❑ **No**

Coverage of the drug is approvable after demonstrated failure to the alternatives below or we receive information as to why they would be inappropriate.

Acute gouty arthritis (gout):
Select the medications the patient has a failure, contraindication, or intolerance to:

❑ Colchicine
❑ Colcrys
❑ EC-Naprosyn
❑ Flurbiprofen
❑ Mitigare
❑ Naprelan
❑ Naproxen
❑ Naproxen delayed-release (DR)
❑ Naproxen sodium
❑ Naproxen sodium ER
❑ Sulindac

Acute painful shoulder (bursitis and/or tendonitis):
Select the medications the patient has a failure, contraindication, or intolerance to:

❑ EC-Naprosyn
❑ Flurbiprofen
❑ Naprelan
❑ Naproxen
❑ Naproxen DR
❑ Naproxen sodium
❑ Naproxen sodium ER
❑ Sulindac

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Ankylosing spondylitis:
Select the medications the patient has a failure, contraindication, or intolerance to:

- ❑ Celebrex
- ❑ Celecoxib
- ❑ Diclofenac sodium DR
- ❑ Diclofenac sodium ER
- ❑ EC-Naprosyn
- ❑ Flurbiprofen
- ❑ Naprelan
- ❑ Naproxen
- ❑ Naproxen DR
- ❑ Naproxen sodium
- ❑ Naproxen sodium ER
- ❑ Sulindac

Osteoarthritis:
Select the medications the patient has a failure, contraindication, or intolerance to:

- ❑ Celebrex
- ❑ Celecoxib
- ❑ Diclofenac potassium
- ❑ Diclofenac sodium
- ❑ Diclofenac sodium DR
- ❑ Diclofenac sodium ER
- ❑ Diflunisal
- ❑ EC-Naprosyn
- ❑ Etodolac
- ❑ Etodolac ER
- ❑ Fenoprofen
- ❑ Flurbiprofen
- ❑ Ibu
- ❑ Ibuprofen
- ❑ Ketoprofen
- ❑ Lodine
- ❑ Meclofenamate
- ❑ Meloxicam
- ❑ Mobic
- ❑ Nabumetone
- ❑ Nalfon
- ❑ Naprelan
- ❑ Naproxen
- ❑ Naproxen DR
- ❑ Naproxen sodium
- ❑ Naproxen sodium ER
- ❑ Pennsaid
- ❑ Profeno
- ❑ Sulindac
- ❑ Tolmetin
- ❑ Vivlodex
- ❑ Zorvolex

Pain:
Select the medications the patient has a failure, contraindication, or intolerance to:

- ❑ Celebrex
- ❑ Celecoxib
- ❑ Diclofenac potassium
- ❑ Diflunisal
- ❑ Duloxetine
- ❑ EC-Naprosyn
- ❑ Etodolac
- ❑ Fenoprofen
- ❑ Ibu
- ❑ Ibuprofen
- ❑ Ketoprofen
- ❑ Meclofenamate
- ❑ Mefenamic acid
- ❑ Nalfon
- ❑ Naprelan
- ❑ Naproxen
- ❑ Naproxen DR
- ❑ Naproxen sodium
- ❑ Naproxen sodium ER
- ❑ Ponstel
- ❑ Profeno
- ❑ Sulindac
- ❑ Zipsor
- ❑ Zorvolex

Rheumatoid arthritis:
Select the medications the patient has a failure, contraindication, or intolerance to:

- ❑ Celebrex
- ❑ Celecoxib
- ❑ Diclofenac potassium
- ❑ Diclofenac sodium DR
- ❑ Diclofenac sodium ER
- ❑ Diflunisal
- ❑ EC-Naprosyn
- ❑ Etodolac
- ❑ Etodolac ER
- ❑ Fenoprofen
- ❑ Flurbiprofen
- ❑ Ibu
- ❑ Ibuprofen
- ❑ Ketoprofen
- ❑ Lodine
- ❑ Meclofenamate
- ❑ Meloxicam
- ❑ Mobic
- ❑ Nabumetone
- ❑ Nalfon
- ❑ Naprelan
- ❑ Naproxen
- ❑ Naproxen DR
- ❑ Naproxen sodium
- ❑ Naproxen sodium ER
- ❑ Profeno
- ❑ Sulindac
- ❑ Tolmetin
- ❑ Vivlodex

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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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.