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

Pennsaid® (diclofenac topical solution)
Prior Authorization Request Form (Page 1 of 2)

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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:

❑ Treatment of the pain of osteoarthritis of the knee(s)
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Will the requested medication be used in the treatment of peri-operative pain in the setting of coronary artery bypass graft surgery? ❑ **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 a 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 NSAIDs, including urticaria and asthma (aspirin-sensitive asthma)? ❑ **Yes** ❑ **No**

Reauthorization:
If this is a reauthorization request, answer the following:

Has the patient experienced a response to therapy (e.g., improvement in pain symptoms of osteoarthritis)? ❑ **Yes** ❑ **No**

Does the patient have a history of severe allergic-type reactions after taking aspirin or other NSAIDs, including urticaria 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 delayed- release (DR)
❑ Diclofenac sodium extended-release (ER)
❑ Diclofenac sodium gel
❑ Diclofenac sodium topical solution
❑ 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
❑ Vivlodex
❑ Voltaren

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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.