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

Voltaren® Gel (diclofenac gel) Prior Authorization Request Form

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:

❑ Topical relief of the pain of osteoarthritis of the knees, hands, wrists, elbows, feet, or ankles
❑ Other diagnosis: _____ ICD-10 Code(s): _____

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

❑ Celecoxib	❑ Flurbiprofen	❑ Naproxen DR
❑ Diclofenac potassium	❑ Ibu	❑ Naproxen sodium
❑ Diclofenac sodium 1% gel	❑ Ibuprofen	❑ Naproxen sodium ER
❑ Diclofenac sodium delayed- release (DR)	❑ Ketoprofen	❑ Oxaprozin
❑ Diclofenac sodium extended-release (ER)	❑ Ketoprofen ER	❑ Piroxicam
❑ Diflunisal	❑ Meclofenamate	❑ Profeno
❑ Etodolac	❑ Meloxicam	❑ Sulindac
❑ Etodolac ER	❑ Nabumetone	❑ Tolmetin
❑ Fenoprofen	❑ Naproxen	❑ Vivlodex

Quantity limit requests:

What is the quantity requested per MONTH? _____

Does the patient require a larger quantity to cover a larger surface area? ❑ **Yes** ❑ **No**

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.

Office use only: VoltarenGel_CMS_2019Feb-W