



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 <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 brand		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

Clinical Information <small>(required)</small>																											
<p>Select the diagnosis below:</p> <p><input type="checkbox"/> Topical relief of the pain of osteoarthritis of the knees, hands, wrists, elbows, feet, or ankles</p> <p><input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p>																											
<p>Select the medications the patient has a failure, contraindication, or intolerance to:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;"><input type="checkbox"/> Celecoxib</td> <td style="width: 33%;"><input type="checkbox"/> Flurbiprofen</td> <td style="width: 33%;"><input type="checkbox"/> Naproxen DR</td> </tr> <tr> <td><input type="checkbox"/> Diclofenac potassium</td> <td><input type="checkbox"/> Ibu</td> <td><input type="checkbox"/> Naproxen sodium</td> </tr> <tr> <td><input type="checkbox"/> Diclofenac sodium 1% gel</td> <td><input type="checkbox"/> Ibuprofen</td> <td><input type="checkbox"/> Naproxen sodium ER</td> </tr> <tr> <td><input type="checkbox"/> Diclofenac sodium delayed- release (DR)</td> <td><input type="checkbox"/> Ketoprofen</td> <td><input type="checkbox"/> Oxaprozin</td> </tr> <tr> <td><input type="checkbox"/> Diclofenac sodium extended-release (ER)</td> <td><input type="checkbox"/> Ketoprofen ER</td> <td><input type="checkbox"/> Piroxicam</td> </tr> <tr> <td><input type="checkbox"/> Diflunisal</td> <td><input type="checkbox"/> Meclofenamate</td> <td><input type="checkbox"/> Profeno</td> </tr> <tr> <td><input type="checkbox"/> Etodolac</td> <td><input type="checkbox"/> Meloxicam</td> <td><input type="checkbox"/> Sulindac</td> </tr> <tr> <td><input type="checkbox"/> Etodolac ER</td> <td><input type="checkbox"/> Nabumetone</td> <td><input type="checkbox"/> Tolmetin</td> </tr> <tr> <td><input type="checkbox"/> Fenoprofen</td> <td><input type="checkbox"/> Naproxen</td> <td><input type="checkbox"/> Vivlodex</td> </tr> </table>	<input type="checkbox"/> Celecoxib	<input type="checkbox"/> Flurbiprofen	<input type="checkbox"/> Naproxen DR	<input type="checkbox"/> Diclofenac potassium	<input type="checkbox"/> Ibu	<input type="checkbox"/> Naproxen sodium	<input type="checkbox"/> Diclofenac sodium 1% gel	<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Naproxen sodium ER	<input type="checkbox"/> Diclofenac sodium delayed- release (DR)	<input type="checkbox"/> Ketoprofen	<input type="checkbox"/> Oxaprozin	<input type="checkbox"/> Diclofenac sodium extended-release (ER)	<input type="checkbox"/> Ketoprofen ER	<input type="checkbox"/> Piroxicam	<input type="checkbox"/> Diflunisal	<input type="checkbox"/> Meclofenamate	<input type="checkbox"/> Profeno	<input type="checkbox"/> Etodolac	<input type="checkbox"/> Meloxicam	<input type="checkbox"/> Sulindac	<input type="checkbox"/> Etodolac ER	<input type="checkbox"/> Nabumetone	<input type="checkbox"/> Tolmetin	<input type="checkbox"/> Fenoprofen	<input type="checkbox"/> Naproxen	<input type="checkbox"/> Vivlodex
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<p>Quantity limit requests:</p> <p>What is the quantity requested per MONTH? _____</p> <p>Does the patient require a larger quantity to cover a larger surface area? <input type="checkbox"/> Yes <input type="checkbox"/> No</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?

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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