PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Topical NSAIDs - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Topical NSAIDs - Priority Partners MCO.

Drug Name (select from list of drugs shown)

Diclofenac epolamine 1.3%	Diclofenac sodium 1.5%	Flector (diclofenac epolamine 1.3%)
Ketorolac tromethamine spray	Pennsaid (diclofenac sodium 2%)	Sprix (ketorolac tromethamine spray)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is this request for continuation of therapy of Pennsaid or generic diclofenac 1.5 percent? Y N

[Note: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]

[If no, then skip to question 3.]

2.	Is the patient showing positive clinical response and tolerance of treatment?	Y N
	[Note: Documentation must be submitted.]	
	[No further questions.]	
3.	Is the patient concurrently using oral nonsteroidal anti-inflammatory drugs (NSAIDs) OR does the patient have known hypersensitivity to Aspirin, nonsteroidal anti-inflammatory drugs (NSAIDs), or Ethylenediaminetetraacetic acid (EDTA)?	Y N
	[If yes, then no further questions.]	
4.	Is this request for the treatment of peri-operative pain in the setting of coronary artery bypass graft (CABG)?	Y N
	[If yes, then no further questions.]	
5.	Is this request for Flector?	Y N
	[If no, then skip to question 11.]	
6.	Is this request for the treatment of chronic pain, or pain associated with venipuncture?	Y N
	[If yes, then no further questions.]	
7.	Does the patient have the diagnosis of acute pain?	Y N
	[Note: Documentation must be submitted.]	
	[If no, then no further questions.]	
8.	Has the patient tried oral diclofenac plus 2 other oral nonsteroidal anti-inflammatory drugs (NSAIDs)?	Y N
	[Note: Documentation must be submitted.]	
	[If yes, then no further questions.]	
9.	Does the patient have history of a documented, severe reaction to an oral nonsteroidal anti-inflammatory drug (NSAID) (e.g. hepatitis, edema, or gastrointestinal hemorrhage, perforation or ulcer)?	Y N
	[Note: Documentation must be submitted.]	
	[If yes, then no further questions.]	
10.	Does the patient have documented inability to take oral medications?	Y N
	[Note: Documentation must be submitted.]	
	[No further questions.]	
11.	Is this request for Pennsaid or generic diclofenac 1.5 percent?	Y N
	[If no, then skip to question 14.]	
12.	Is this request for the treatment of Osteoarthritis (OA) pain of the knee?	Y N
	[Note: Documentation must be submitted.]	
	[If no, then no further questions.]	

13. Has the patient tried oral diclofenac plus 2 other oral nonsteroidal anti-inflammatory drugs (NSAIDs), and generic diclofenac 1 percent gel?	Y N	
[Note: Documentation must be submitted.]		
[No further questions.]		
14. Is this request for Sprix?	Y N	
[If no, then no further questions.]		
15. Does the patient have the diagnosis of moderate to severe short term pain?	Y N	
[Note: Documentation must be submitted.]		
[If no, then no further questions.]		
16. Is this request for use as a prophylactic analgesic before any major surgery?	Y N	
[If yes, then no further questions.]		
17. Does the patient have any of the following: A) Peptic ulcer disease (PUD) or gastrointestinal (GI) bleeds, B) Advanced renal impairment or at risk for renal failure, C) High risk for bleeding or have cerebrovascular bleeding?	Y N	
[If yes, then no further questions.]		
18. Has the patient tried at least 3 formulary oral nonsteroidal anti-inflammatory drugs (NSAIDs)?	Y N	
[Note: Documentation must be submitted.]		
[If yes, then no further questions.]		
19. Does the patient have history of a documented, severe reaction to an oral nonsteroidal anti-inflammatory drug (NSAID) (e.g. hepatitis, edema, or gastrointestinal hemorrhage, perforation or ulcer)?	Y N	
[Note: Documentation must be submitted.]		
[If yes, then no further questions.]		
20. Does the patient have documented inability to take oral medications?	Y N	
[Note: Documentation must be submitted.]		

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date