Prior Authorization Request Form for
diclofenac potassium liquid filled capsules **(Zipsor),** diclofenac, submicronized **(Zorvolex)** indomethacin submicronized **(Tivorbex),** naproxen CR **(Naprelan/ generics),** meloxicam submicronized **(Vivlodex)**

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

**FAX Completed Form and Applicable Progress Notes to: (410) 424-4037**

# USFHP Pharmacy Prior Authorization Form

| To be completed by Requesting provider | |
|---|---|
| Drug Name: | Strength: |
| Dosage/Frequency (SIG): | Duration of Therapy: |

***Questions?*** Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

**Step 1** **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

**Step 2** **Please complete the clinical assessment:**

| | |
|---|---|
| 1. **Multiple formulary NSAIDs are available for DoD beneficiaries without a prior authorization. Please provide the clinical rationale as to why the patient cannot take any of the formulary NSAIDs** | **Sign and date below** |

Please Note: The formulary NSAID products (diclofenac potassium, diclofenac sodium, etodolac, fenoprofen, flurbiprofen, ibuprofen, indomethacin, ketoprofen, oral ketorolac, meclofenamate, meloxicam, nabumetone, naproxen, naproxen sodium, oxaprozin, piroxicam, sulindac, tolmetin, naproxen-esomeprazole [Vimovo], diclofenac-misoprostol [Arthrotec], and celecoxib [Celebrex]).

**Step 3** **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[15 May 2019]

| **For Internal Use Only** | |
|---|---|
| ☐ Approved: | Duration of Approval: _____month(s) |
| ☐ Denied: | Authorized By: |
| ☐ Incomplete/Other: | PA#: |
| Date Faxed to MD: | Date Decision Rendered: |