iowa total care | ia health link | Hawki | envolve Pharmacy Solutions

**FAX Completed Form To**
1.877.386.4695

**Provider Help Desk**
1.866.399.0928

# Request for Prior Authorization
# NONSTEROIDAL ANTI-INFLAMMATORY DRUGS

(PLEASE PRINT – ACCURACY IS IMPORTANT)

| IA Medicaid Member ID # | Patient name | DOB |
|---|---|---|
| Patient address | | |
| Provider NPI | Prescriber name | Phone |
| Prescriber address | | Fax |
| Pharmacy name | Address | Phone |

**Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.**

| Pharmacy NPI | Pharmacy fax | NDC |
|---|---|---|

**Prior authorization is required for all non-preferred nonsteroidal anti-inflammatory drugs (nsaids) and COX-2 inhibitors. Prior authorization is not required for preferred nsaids or COX-2 inhibitors. 1. Requests for a non-preferred nsaid must document previous trials and therapy failures with at least three preferred nsaids. 2. Requests for a non-preferred COX-2 inhibitor must document previous trials and therapy failures with three preferred nsaids, two of which must be preferred COX-2 preferentially selective nsaids. 3) Requests for a non-preferred extended release nsaid must document previous trials and therapy failures with three preferred nsaids, one of which must be the preferred immediate release nsaid of the same chemical entity at a therapeutic dose that resulted in a partial response with a documented intolerance. The required trials may be overridden when documented evidence is provided that use of these agents would be medically contraindicated.**

**Preferred (No PA required)**

- ☐ Celecoxib (COX-2)
- ☐ Diclofenac Sod/Pot
- ☐ Diclofenac Sod. EC/DR
- ☐ Etodolac 400mg/500mg
- ☐ Flurbiprofen
- ☐ Ibuprofen
- ☐ Ibuprofen Susp
- ☐ Indomethacin
- ☐ Ketoprofen
- ☐ Meloxicam (COX-2)
- ☐ Nabumetone (COX-2)
- ☐ Naproxen Tab
- ☐ Naproxen EC/ER
- ☐ Naproxen sod 550mg
- ☐ Salsalate
- ☐ Sulindac
- ☐ Voltaren Gel

**Non-Preferred (PA required for all products)**

- ☐ Arthrotec
- ☐ Celebrex
- ☐ Diclofenac ER/XR*
- ☐ Diclofenac Epolamine
- ☐ EC-Naprosyn
- ☐ Etodolac CR/ER/XR
- ☐ Fenoprofen
- ☐ Flector Patch
- ☐ indomethacin ER*
- ☐ ketoprofen ER
- ☐ Meclofenamate Sod
- ☐ Naprelan
- ☐ Naproxen Susp
- ☐ Oxaprozin
- ☐ Pennsaid
- ☐ Piroxicam
- ☐ Qmiiz ODT
- ☐ Tivorbex
- ☐ Tolmetin Sod
- ☐ Vivlodex
- ☐ Zipsor
- ☐ Zorvolex

☐ **Other** (specify) _____

**Strength**_____ **Dosage Instructions**_____**Quantity**_____ **Days Supply**_____

**Diagnosis:**_____

**Preferred Drug Trial 1**: Drug Name& Dose_____ Trial Dates:_____

Failure Reason_____

**Preferred Drug Trial 2**: Drug Name& Dose_____ Trial Dates:_____

Failure Reason_____

**Preferred Drug Trial 3**: Drug Name& Dose_____ Trial Dates:_____

Failure Reason_____

Medical Necessity for alternative delivery system: _____

Medical or contraindication reason to override trial requirements: _____

Reason for use of Non-Preferred drug requiring prior approval:_____

***Attach lab results and other documentation as necessary.***

| Prescriber signature (Must match prescriber listed above.) | Date of submission |
|---|---|

***IMPORTANT NOTE:*** *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*