AmeriHealth Caritas New Hampshire

Legend Topical NSAIDs Agents

Prior Authorization Drug Approval Form

Date of medication request: (MM/DD/YYYY): ____ / ____ / _____

Patient information and medication requested	
Patient's name:	Medicaid number:
Date of birth:	Gender:
Drug name:	Strength:
Dosing directions:	Length of therapy:

Prescriber information		
Prescriber name:		NPI number:
Prescriber address:		Prescriber representative:
Phone #:	Fax #:	

Clinical history
1. Is the patient 18 years of age or older? ☐ Yes ☐ No
2. Has the patient tried and failed an oral generic diclofenac product?
3. Has the patient tried and failed an oral generic NSAID product? ☐ Yes ☐ No If yes to #3, list medication names:
4. Is the patient unable to swallow, tolerate, or absorb oral medications? ☐ Yes ☐ No
5. Will the patient be on concurrent oral NSAIDS? ☐ Yes ☐ No
6. Is the patient undergoing coronary artery bypass graft (CABG) surgery? ☐ Yes ☐ No
7. Does the patient have a history of gastrointestinal contraindications to oral NSAIDS? ☐ Yes ☐ No
Provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

Signature of prescriber:_____ Date: _____
(prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.