PriorityHealth

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: ☐ **Commercial (Traditional)** ☐ **Commercial Individual (Optimized)** ☒ **Medicaid**

This request is: ☐ **Urgent** (life threatening) ☐ **Non-Urgent** (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Diclofenac 3% gel

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____ Gender: _____

Primary Care Physician: _____

Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____

Provider Address: _____

Provider NPI: _____ Contact Name: _____

Provider Signature: _____ Date: _____

Product Information

☐ New request ☐ Continuation request

Drug product: ☐ Diclofenac 3% gel

Start date (or date of next dose): _____

Date of last dose (if applicable): _____

Dosing frequency: _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements (initial approval 3 months):

1. Must have a diagnosis of actinic keratosis; AND
2. Must have had an inadequate response or intolerance to office-based treatments (liquid nitrogen cryotherapy, surgical curettage) or have been considered and ruled out due to nature/number of lesions or limited resources to provide such treatments; AND
3. Must have had an inadequate response to a full treatment or intolerance/contraindication to a trial of imiquimod; AND
4. Must have had an inadequate response to a full treatment or intolerance/contraindication to a trial of 5-fluorouracil.

For continuation, patient must have met the following requirements (continued approval 3 months):

1. Must have documentation that there has been a positive response to therapy.
2. If there is no demonstrable clinically significant improvement in condition continued treatment will not be approved.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

All fields must be complete and legible for review. Your office will receive a response via fax. No changes made since 03/2018

Last reviewed 07/2020

PriorityHealth

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Actinic keratosis
- ☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. Has the patient had an inadequate response to office-based treatments (liquid nitrogen cryotherapy, surgical curettage)?

- ☐ Yes, *describe*: _____
- ☐ No, *reason*: _____

C. Has the patient had an inadequate response to a full treatment course of imiquimod?

- ☐ Yes, Dates: _____ Outcome: _____
- ☐ No, *rationale*: _____

D. Has the patient had an inadequate response to a full treatment course of 5-fluorouracil?

- ☐ Yes, Dates: _____ Outcome: _____
- ☐ No, *rationale*: _____

Request to continue a previously authorized approval
Priority Health Precertification Documentation

A. What condition is this drug being requested for?

- ☐ Actinic keratosis
- ☐ *Other – the patient's condition is:* _____

Rationale for use: _____

B. Did the patient have a clinically significant improvement in condition after initiation of diclofenac 3% gel?

- ☐ Yes
- ☐ No

Additional information

Note: Diclofenac 3% gel is limited to 100 grams every 30 days. Approval will be granted in 3 month intervals (new request required every 3 months for continuation).

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