

# 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.

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**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: \_\_\_\_\_

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**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

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**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).