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.

Naproxen suspension

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: ☐ Naproxen 125 mg/5 mL suspension

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:

1. Must be age 12 years and younger.
2. Must be prescribed by a rheumatologist.
3. Must be using for a diagnosis of: Rheumatoid Arthritis, Osteoarthritis, Ankylosing Spondylitis, or Juvenile Rheumatoid Arthritis.
4. Must have had a trial and failure of ibuprofen suspension or a clinical reason ibuprofen suspension cannot be used.

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.

New request
Priority Health Precertification Documentation

A. What condition is this drug being requested for? _____

B. Is prescriber a rheumatologist?

☐ Yes
☐ No

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 03/2019

C. Has patient had a trial and failure of ibuprofen suspension?

☐ Yes, *list dose tried, dates, and outcomes:* _____

_____

☐ No, *clinical rationale*: _____

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Last reviewed 03/2019