CAREFIRST F3
Pennsaid / Topical Nonsteroidal Anti-Inflammatory Drugs (NSAIDS)

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 800-294-5979 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Pennsaid / Topical Nonsteroidal Anti-Inflammatory Drugs (NSAIDS) .

Patient Information

Patient Name: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Patient Phone: ☐☐☐-☐☐☐-☐☐☐☐

Patient ID: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Patient Group: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Patient DOB: ☐☐/☐☐/☐☐☐☐

Physician Information

Physician Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Physician Phone: ☐☐☐-☐☐☐-☐☐☐☐

Physician Fax: ☐☐☐-☐☐☐-☐☐☐☐

Physician Addr.: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

City, St, Zip: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Drug Name (select from list of drugs shown)

Pennsaid (diclofenac sod topical soln 2%) Diclofenac Top Sol 1.5% Diclofenac Sol 2%

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

1.	Does the patient have osteoarthritis pain of the knee(s)?	**Y** ☐	**N** ☐
2.	Is this request for continuation of therapy?	**Y** ☐	**N** ☐
3.	Has the patient achieved or maintained a positive clinical response to the requested drug?	**Y** ☐	**N** ☐
4.	Has the patient been re-evaluated periodically to determine if treatment is still necessary?	**Y** ☐	**N** ☐
5.	Does the patient require MORE than the plan allowance of 2 bottles per month?	**Y** ☐	**N** ☐
6.	Is treatment with the requested drug necessary due to a concern about intolerance to oral nonsteroidal anti-inflammatory drugs (NSAIDs)?	**Y** ☐	**N** ☐
7.	Is treatment with the requested drug necessary due to a contraindication to oral nonsteroidal anti-inflammatory drugs (NSAIDs)?	**Y** ☐	**N** ☐
8.	Does the patient require MORE than the plan allowance of 2 bottles per month?	**Y** ☐	**N** ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

Prescriber (Or Authorized) Signature and Date

Now you can get responses to drug PAs immediately and securely online—without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.