Prior Authorization Form

CAREFIRST

Diclofenac Sodium Gel 3%

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Diclofenac Sodium Gel 3%.

Drug Name (select from list of drugs shown)
Diclofenac Sodium 3% Transdermal Gel

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1.	Is the requested drug [diclofenac sodium gel 3 percent (generic Solaraze)] being prescribed for the treatment of actinic keratoses (AK)?	Y N
	[If Yes, go to 2. If No, then no further questions.]	
2.	Is the request for continuation of therapy?	Y N
	[If Yes, go to 3. If No, go to 4.]	
3.	Has the patient achieved or maintained a positive clinical response as evidenced by improvement (e.g., percentage of actinic keratosis lesions cleared, patient/prescriber satisfaction, etc.)?	Y N

	[If Yes, go to 5. If No, then no further questions.]
4.	Has the patient experienced an inadequate treatment response, intolerance, or does the patient have a contraindication to ONE of the following: A) imiquimod 5 percent cream, B) fluorouracil cream or solution? Y N
	[If Yes, go to 5. If No, then no further questions.]
5.	Does the patient require MORE than the plan allowance of 100 grams per month? Y N
	[No further questions.]

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