

Request for Prior Authorization NONSTEROIDAL ANTI-INFLAMMATORY DRUGS



Provider Help Desk I (844) 236-1464

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To1 (877) 733-3195

IA Medicaid Member ID #	Patient name			DOB	
Patient address					
Provider NPI Prescriber na		name		Phone	
Prescriber address				Fax	
Pharmacy name Address				Phone	
Prescriber must complete all info	rmation above. It n	nust be legible, correct, and o	complete or fo	orm will be returned.	
Pharmacy NPI	Pharmacy fa	Pharmacy fax		NDC S (NSAIDs). Payment for a non-preferred NSAID	
will be considered under the following on NSAIDs; and 2. Requests for a non-prefold NSAIDs, one of which must be the prefold partial response with a documented into these agents would be medically contra	onditions: I. Docume erred extended releas erred immediate relea olerance. The require	entation of previous trials and the e NSAID must document previouse ase NSAID of the same chemical ed trials may be overridden wher	erapy failures wi ous trials and the entity at a ther n documented e	th at least three preferred erapy failures with three preferred apeutic dose that resulted in a vidence is provided that use of	
Preferred (No PA required)		Non-Preferred (PA requi	Non-Preferred (PA required for all products)		
Diclofenac Sod/Pot Meloxi Diclofenac Sod. EC/DR Nabum Diclofenac Sod Gel I% Napro: Etodolac 400mg/500mg Napro: Flurbiprofen Napro: Salsalat	Meloxicam (COX-2) ac Sod. EC/DR Nabumetone (COX-2) ac Sod Gel 1% Naproxen Tab Naproxen EC/ER Naproxen sod 550mg n Salsalate n Susp		Flector Oxaprozin Indomethacin ER* Pennsaid Ketoprofen ER Piroxicam Licart Tolmetin Sod Meclofenamate Sod Vivlodex Meloxicam Caps Naprelan Naproxen ER 750mg Naproxen Susp		
		Other (specify)			
Strength Dosage	Instructions	Qua	ntity	Days Supply	
Diagnosis: Preferred NSAID Trial I: Drug N	Name& Dose		Trial		
Failure Reason					
Preferred NSAID Trial 2: Drug Name& Dose			Trial Dates:		
Failure Reason	Name& Dose		Trial	Dates:	
Failure Reason					
Medical Necessity for alternative del	ivery system:				
Medical or contraindication reason t	o override trial requ	uirements:			
Reason for use of Non-Preferred dr Attach lab results and other docu					
Prescriber signature (Must match prescriber listed above.)			Date of submission		

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.