10181 Scripps Gateway Court
San Diego, CA 92131

MedImpact

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Diclofenac (Topical) Prior Authorization Request Form

This form **can** be used to request:

- Diclofenac 2% (Pennsaid) OR Diclofenac 3% (Solaraze)

Patient Information			**Prescriber Information**			
Patient Name:			Prescriber Name:			
Member ID#			DEA#		NPI#	
Address:			Address:			
City:		State	City:			State:
Home Phone:		Zip:	Office Phone:	Office Fax:		Zip:
Sex (circle): M F	DOB:		Contact Person:			

Diagnosis and Medical Information			
Medication:	Directions for use: (Frequency & Strength):		
0 New Prescription OR Date Therapy Initiated**:**	Expected Length of Therapy: Route of Administration:		Qty: Qty per month:
Height/Weight:	Drug Allergies:	Diagnosis Code (ICD-10):	
Prescriber's Signature:	MD Specialty:		Date:

Rationale for Exception Request or Prior Authorization
FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION

Documentation of Medical Necessity:

Is the request for one of the following diagnoses?

☐ Osteoarthritis of the knee(s) ☐ Actinic keratosis (AK)

If no, please provide member's associated diagnosis: ______________________________

Request for Expedited Review

0 **REQUEST FOR EXPEDITED REVIEW [24 HOURS]**

0 BY CHECKING THIS BOX AND SIGNING ABOVE, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION

Information on this form is protected Health Information and subject to all privacy and security regulations under HIPAA.

Created: 11/18 Reviewed/Revised: 11/18