AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Flector® Patch (diclofenac epolamine 1.3%)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member must meet **BOTH** of the following **(verified by chart notes and/or pharmacy paid claims)**:
  - ❑ Member has tried and failed diclofenac 1% gel (generic Voltaren® Gel)
  - ❑ Member has tried and failed at least **four (4)** NSAIDs **(check all that apply)**

❑ diclofenac sodium	❑ diflunisal	❑ etodolac
❑ fenoprofen	❑ flurbiprofen	❑ ibuprofen
❑ indomethacin, SR	❑ ketoprofen, SR	❑ ketorolac
❑ meclofenamate	❑ nabumetone	❑ naproxen
❑ naproxen sodium	❑ oxaprozin	❑ piroxicam
❑ sulindac	❑ tolmetin	❑ meloxicam

(Continued on next page)

Not all drugs may be covered under every Plan.
If a drug is non-formulary on a Plan, documentation of medical necessity will be required.
*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****
****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee**: **2/19/2015**
REVISED/UPDATED/REFORMATTED: ~~11/28/2017; 3/1/2018; (Reformatted) 6/11/2019; 1/22/2020,~~ **2/20/2025**