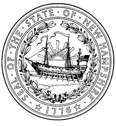

New Hampshire AIDS Drug Assistance Program
Prior Authorization Drug Approval Form

Legend Topical NSAIDs Agents

DATE OF MEDICATION REQUEST: / /

SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

FIRST NAME:

MEDICAID ID NUMBER:

DATE OF BIRTH: – –

GENDER: ☐ Male ☐ Female

Drug Name

Strength

Dosing Directions

Length of Therapy

SECTION II: PRESCRIBER INFORMATION

LAST NAME:

FIRST NAME:

SPECIALTY:

NPI NUMBER:

PHONE NUMBER: – –

FAX NUMBER: – –

SECTION III: CLINICAL HISTORY

1. Is the patient 18 years of age or older? ☐ Yes ☐ No
   a. If *no*, is the request for Flector Patch®, Licart® or a generic equivalent AND is the patient ≥ 6 years old? ☐ Yes ☐ No
2. Is the request for diclofenac sodium 3% gel for the treatment of actinic keratosis? ☐ Yes ☐ No
   If yes, skip to question 5.
3. Has the patient tried and failed an oral generic diclofenac product? ☐ Yes ☐ No
4. Has the patient tried and failed an oral generic NSAID product? ☐ Yes ☐ No
   a. If *yes* to question 3, list medication name(s):
5. Is the patient unable to swallow, tolerate, or absorb oral medications? ☐ Yes ☐ No

(Form continues on the next page.)

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Review date: 02/24/2021

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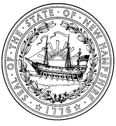

New Hampshire AIDS Drug Assistance Program
Prior Authorization Drug Approval Form

Legend Topical NSAIDs Agents

DATE OF MEDICATION REQUEST: / /

PATIENT LAST NAME:	**PATIENT FIRST NAME:**

SECTION III: CLINICAL HISTORY *(Continued)*

6. Will the patient be on concurrent oral NSAIDS? ☐ Yes ☐ No
7. Is the patient undergoing coronary artery bypass graft (CABG) surgery? ☐ Yes ☐ No
8. Does the patient have a history of gastrointestinal contraindications to oral NSAIDS? ☐ Yes ☐ No

Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

PRESCRIBER'S SIGNATURE: ____ **DATE**: ______________________

Phone: 1-800-424-7901
Fax: 1-800-424-7984

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