# US Family Health Plan
# Prior Authorization Request Form for
# diclofenac potassium powder packets 50 mg (***Cambia***)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
**Attn: Pharmacy, 77 Warren St, Brighton, MA 02135**

QUESTIONS? **Call 1-877-880-7007**

Medical documentation may be required. Failure to provide could result in denial.

**Prior authorization expires in one year. No renewal allowed. When the PA expires, the next fill/refill will require submission of a new PA.**

**Step 1** **Please complete patient and physician information** (please print):

| | | | |
|---|---|---|---|
| Patient Name: | | Physician Name: | |
| Address: | | Address: | |
| | | | |
| Sponsor ID #: | | Phone #: | |
| Date of Birth: | | Secure Fax #: | |

**Step 2** **Please complete the clinical assessment:**

| | | |
|---|---|---|
| **1. Multiple formulary NSAIDS and triptans are available to treat migraine headache that don't require prior authorization, including ibuprofen, indomethacin, naproxen, diclofenac potassium tablets, sumatriptan, rizatriptan, and zolmitriptan. Please consider changing the prescription to one of these preferred agents.** | ☐ Acknowledged<br>Proceed to question **2** | |
| **2. Is the patient greater than or equal to 18 years of age?** | ☐ Yes<br>Proceed to question **3** | ☐ No<br>**STOP**<br>Coverage not approved |
| **3. Does the patient have a diagnosis of migraine headache?** | ☐ Yes<br>Proceed to question **4** | ☐ No<br>**STOP**<br>Coverage not approved |
| **4. Is the prescription written by or in consultation with a neurologist?** | ☐ Yes<br>Proceed to question **5** | ☐ No<br>**STOP**<br>Coverage not approved |

| | | |
|---|---|---|
| **5. Has the patient tried and failed at least two formulary NSAIDs including diclofenac potassium tablets (Cataflam generic)?** | ☐ Yes<br>Proceed to question **6** | ☐ No<br>**STOP**<br>Coverage not approved |
| **6. Has the patient tried and failed at least one formulary triptan (for example, sumatriptan, rizatriptan, and zolmitriptan)?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>Proceed to question **7** |
| **7. Does the patient have a contraindication to at least one formulary triptan (for example, sumatriptan, rizatriptan, and zolmitriptan)?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>Coverage not approved |

**Step 3** **I certify the above is true to the best of my knowledge.** Please sign and date:

Prescriber Signature _____ Date _____