USFHP Prior Authorization Request Form for diclofenac epolamine (Licart)

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

https://www.usfamilyhealth.org/for-providers/pharmacy-information/

Initial therapy approves for 6 months, renewal of therapy is not allowed. When the prior authorization expires, the next fill/refill will require submission of a new prior authorization. Clinical documentation may be required.

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. Is the patient 18 years of age or older?	☐ Yes Proceed to question **2**	☐ No **STOP** Coverage not approved
2. Does the patient have acute pain due to minor strains, sprains, and/or contusions?	☐ Yes Proceed to question **3**	☐ No **STOP** Coverage not approved
3. Is the patient unable to tolerate an oral NSAID due to renal insufficiency, history of gastrointestinal bleed, or other adverse events?	☐ Yes **Sign and date below**	☐ No Proceed to question **4**
4. Has the patient tried and failed TWO oral NSAIDs?	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

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

_____ _____

Prescriber Signature Date

[26 August 2020]