BLUE CROSS AND BLUE SHIELD OF RHODE ISLAND MANAGED CARE

Pennsaid

This fax machine is located in a secure location as required by HIPAA regulations.

Complete/review information, sign and date. Fax signed forms to CVS|Caremark at **1-888-836-0730**.

Please contact CVS|Caremark at **1-877-203-0814** with questions regarding the prior authorization process.

When conditions are met, we will authorize the coverage of Pennsaid.

Drug Name (select from list of drugs shown)

Pennsaid (diclofenac sodium soln)

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Please circle the appropriate answer for each applicable question.

1. Does the patient require the NSAID treatment for pain relief in only one area or joint [e.g. knee(s)] in the body? Y N

   [If the answer to this question is no, then no further questions are necessary.]

2. Has the patient demonstrated an inadequate treatment response to, intolerance to, or had a confirmed adverse event to at least TWO prescription NSAIDs (one being oral diclofenac) or salicylates? Y N

3. Is the patient unable to tolerate oral therapy? Y N

4. Does the patient have a history of asthma, urticaria or other allergic type reactions after taking aspirin or other NSAIDs? Y N

Comments: _____

I affirm that the information given on this form is true and accurate as of this date.

_____

Prescriber (Or Authorized) Signature and Date