



**DICLOFENAC SODIUM TOPICAL GEL 1% (VOLTAREN® GEL)
PRIOR REVIEW/CERTIFICATION FAXBACK FORM**

**INCOMPLETE FORMS MAY DELAY PROCESSING
ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT BCBSNC PROVIDER ID# BELOW**

PRESCRIBER INFORMATION		PATIENT INFORMATION
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH
PRACTICE ADDRESS	CITY	STATE
		ZIP

Please answer the questions below:

Dx Code: _____

1. Is the patient 18 years of age or older?..... Yes No

2. Is Voltaren Gel being prescribed for treatment of pain due to osteoarthritis involving the elbow, wrist, hand, knee, ankle and/or foot? Yes No

AND meets at least one of the following criteria below:

- Patient has had at least a 1-week trial of a therapeutic dose of an oral NSAID
- Patient has experienced intolerable side effects to oral NSAIDs
- Patient has risks for upper gastrointestinal (GI) bleeding, such as one of the following:
 - a. Age 60 years or greater
 - b. History of peptic ulcer disease or ulcer/GI bleeding related to oral NSAIDs
 - c. Current regimen includes anticoagulant, prescription anti-platelet drug, corticosteroid or DMARD (disease-modifying and anti-rheumatic drug) therapy
 - d. Hereditary or acquired coagulation defect (e.g., hemophilia, Von Willebrand's disease, protein C or S deficiency, thrombocytopenia or chronic renal failure)
- Patient is unable to swallow a tablet or capsule

3. Will the patient be taking an oral NSAID (includes COX-2 inhibitors) to treat the same condition as Voltaren Gel? Yes No

4. Is Voltaren Gel being prescribed for treatment of pain involving the spine, hip, or shoulder? Yes No

Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required): _____ Date: _____

For BCBSNC members, fax form to 1-800-795-9403