

**Prior Authorization Form**  
Date Criteria: 6/21/2010  
**CAREFIRST BLUECROSS BLUESHIELD**  
Flector

Complete information, sign and date. Fax completed forms to Argus at 1-800-315-4025.  
This fax machine is located in a secure location as required by HIPAA regulations.

When conditions are met, we will authorize coverage of Flector  
Please contact Argus at 1-800-314-2872 with questions regarding the prior authorization process.

**Drug Name:** \_\_\_\_\_

**Patient:**

Patient Name: \_\_\_\_\_

Patient ID: \_\_\_\_\_

Patient's Group Number: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

**Prescribing Physician:**

Physician Name: \_\_\_\_\_

Physician Phone: \_\_\_\_\_

Physician Fax: \_\_\_\_\_

Prescriber NPI: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Physician City, State, Zip: \_\_\_\_\_

**WARNING: CARDIOVASCULAR AND GASTROINTESTINAL RISK**

*See full prescribing information for complete boxed warning.*

**Cardiovascular Risk**

- Non-steroidal anti-inflammatory drugs (NSAIDs) may cause an increased risk of serious cardiovascular thrombotic events, myocardial infarction, and stroke, which can be fatal.
- Flector® Patch are contraindicated for the treatment of peri-operative pain in the setting of coronary artery bypass graft (CABG) surgery.

**Gastrointestinal Risk**

- Non-steroidal anti-inflammatory drugs (NSAIDs), including Flector® Patch, cause an increased risk of serious gastrointestinal adverse events including bleeding, ulceration, and perforation of the stomach or intestines, which can be fatal. Elderly patients are at greater risk for serious gastrointestinal events.

1. Is the patient being treated for acute pain due to minor strains, sprains or contusions?  Y  N  
If no, please specify diagnosis. \_\_\_\_\_

2. In the past, has the patient tried and failed therapy with two prescription strength nonsteroidal anti-inflammatory drugs (NSAIDs) for the treatment of acute pain?  Y  N

If yes, please provide the names of the drugs, including strength and dosage and date of trial.

Drug	Strength	Date of Trial
_____	_____	_____
_____	_____	_____

3. Will Flector patch be prescribed for more than 2 weeks?  Y  N  
(Limited to one box of 30 patches per 30 days)

Comments: \_\_\_\_\_

*Information given on this form is accurate as of this date.*

***I have read the Black Box Warning and would like to continue prescribing the drug listed above.***

\_\_\_\_\_  
Prescriber or Authorized Signature

\_\_\_\_\_  
Date