Licart®
(diclofenac epolamine) topical system 1.3%

Note: Faxed prescriptions will only be accepted from a prescribing practitioner. Patients must bring an original prescription to the pharmacy. Prescribers are reminded patients may choose any pharmacy of their choice.

Prescription Referral Form

NPI:_____ Phone: _____ Fax: _____

1 Patient Information

Please fax FRONT and BACK copy of ALL Insurance cards (Prescription and Medical).

Patient Name: _____ Birthdate: _____ Sex: ❑ Male ❑ Female Height: _____ Weight: _____ ❑ lbs. ❑ kg.

Allergies: _____ Patient Primary Language: ❑ English ❑ Spanish ❑ Other: _____ ❑ Hearing Impaired

Patient Phone: _____ Patient Email: _____ Caregiver Name: _____

Patient Address: _____ City: _____ State: _____ Zip: _____

2 Diagnosis/Clinical Information

Please FAX Clinical Notes, Labs, & Tests with the prescription to expedite Prior Authorization.

Check all that apply. Be sure to complete the information on the right-hand side.

Diagnosis:

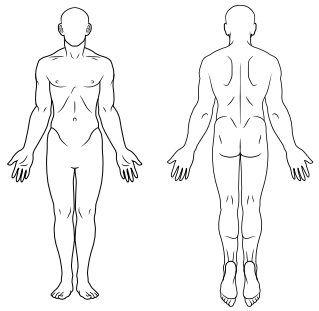
❑ Strain ❑ Contusion
❑ Sprain ❑ Other: _____

In the prescriber's opinion, Licart® is the best treatment option for the patient because:

❑ The alternatives would not be as effective for treating the patient's condition.
❑ The alternatives would likely have adverse effects.
❑ Patient is stable on current medication and changing to an alternative would likely cause adverse effects.
❑ The oral alternatives are contraindicated for the patient – explain: _____
❑ Other: _____

Additional Information: _____

Areas Involved:



❑ Back ❑ Arm ❑ Shoulder ❑ Knee
❑ Neck ❑ Legs ❑ Foot/Calf ❑ Other

Prior Medications Used: Must be completed for all patients.

Treatment Type	Strength	Dates of Use
❑ Ibuprofen		
❑ Diclofenac Oral		
❑ Diclofenac Patch		
❑ Mefenamic Acid		
❑ Indomethacin		
❑ Naproxen		
❑ Diclofenac Topical		
❑ Celecoxib		
❑ Etoricoxib		
❑ Aspirin		
❑ Other: _____		

3 Prescription Information

Please be sure to choose both induction and maintenance dose where applicable.

Medication	Dose/Strength	Direction	Qty.	Refills
❑ LICART®	❑ 1.3% Patch	❑ Dose: Apply one patch topically to clean, dry, hairless area once daily. ❑ Other: _____	❑ 90 ❑ ___	❑ ___
❑ _____	❑ _____	❑ _____	❑ ___	❑ ___

4 Provider/Prescriber Information

Clinic Name: _____ Provider Name: _____

Provider Phone: _____ Provider Fax: _____ DEA#: _____ NPI#: _____

Provider Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: Prescriber, please sign and date below (NO stamps please):

Signature: _____ Date: _____

Dispense as Written (Write "DAW")

I authorize this pharmacy and its representatives to act as an agent to initiate and execute the insurance Prior Authorization process, nursing services, and patient assistance programs.