02/17/2015

Fallon Community Health Plan MassHealth

FCHP (MEDICAID)

Zorvolex Step Therapy (FCHP)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Fallon Community Health Plan MassHealth at **1-855-762-5204**.
Please contact Fallon Community Health Plan MassHealth at **1-866-643-5126** with questions regarding the Fallon Community Health Plan MassHealth process.
When conditions are met, we will authorize the coverage of Zorvolex Step Therapy (FCHP).

Drug Name (select from list of drugs shown)

Zorvolex Capsules (diclofenac)

Quantity _____ **Frequency** _____ **Strength** _____

Route of Administration _____ **Expected Length of Therapy** _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Has the patient tried and failed generic diclofenac sodium? Y N
   [If the answer to this question is yes, no further questions required.]
2. Is the patient intolerant to generic diclofenac sodium? Y N

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

_____

Prescriber (Or Authorized) Signature and Date