PRIOR AUTHORIZATION CRITERIA

BRAND NAME (generic)

NAPRELAN (naproxen sodium extended release)

Status: Client Requested Criteria Type: Initial Prior Authorization

Ref # C14107-A

CRITERIA FOR APPROVAL					
1	Is the patient 18 years of age or older? [If no, then no further questions.]	Yes	No		
2	Is the requested drug being prescribed for the relief of the signs and symptoms of any of the following: A) Rheumatoid Arthritis, B) Osteoarthritis, C) Ankylosing Spondylitis, D) Gouty Arthritis, E) Mild to Moderate Pain? [If no, then no further questions.]	Yes	No		
3	Has the patient had an inadequate treatment response to BOTH immediate-release and delayed-release naproxen?	Yes	No		

Mapping Instructions				
	Yes	No		
1.	Go to 2	Deny		
2.	Go to 3	Deny		
3.	Approve, 12 months	Deny		

REFERENCES

Ν/Δ

Written by: UM Development (ME)

Date Written: 08/2018

Revised:

Reviewed: Medical Affairs: (CW) 08/2018

The Participating Group signed below hereby accepts and adopts as its own the criteria for use with Prior Authorization, as administered by CVS Caremark.							
Signature	Date						
Client Name	-						

Naprelan NCSHP C14107-A 08-2018.docx

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