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
N/A

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

CVS caremark™