MEDLY PHARMACY

Flector® (diclofenac epolamine) topical system

Licart™ (diclofenac epolamine) topical system 1.3%

5 Science Park, Ste 1 New Haven, CT 06511
T: 833-497-7370 F: 203-497-7371 Medly Mail NPI: 1740771021

Please detach before submitting to a pharmacy.

PATIENT INFORMATION: Complete or include demographic sheet

Full Name:	DOB:	SSN:
Sex: ☐ Male ☐ Female Preferred Pronouns:	Primary Language:	
Address:		
City:	State:	Zip:
Phone #:	Alternate Phone #:	
Allergies (Required): ☐ NKDA	Height:	Weight:
Product Shipping Options: ☐ Patient's Home ☐ Prescriber's Office ☐ Alternative Address:		

PRESCRIBER INFORMATION

Practice Name:	Office Contact:	
Prescriber Name:	NPI:	DEA:
Practice Address:		
City:	State:	Zip:
Phone #:	Fax #:	

CLINICAL INFORMATION

Diagnosis:

☐ Strain ☐ Contusion

☐ Sprain ☐ Other:

In the prescriber's opinion, Flector/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.

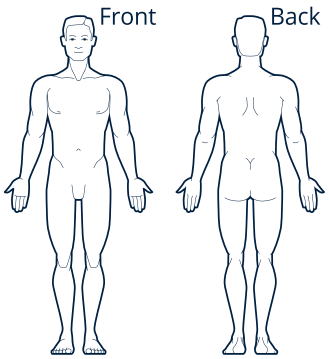
☐ Patient is stable on current medication and changing to an alternative would likely cause adverse effects.

☐ 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:

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

PRESCRIPTION INFORMATION

MEDICATION	DOSE	DIRECTIONS	QUANTITY	REFILLS
☐ **Flector®** 15 Patches per Box	☐ 1.3% Patch 15 Patches per Box	☐ **Dose:** Apply one patch topically to clean, dry, hairless area BID. ☐ Other: _____	☐ 1 Box of 15 Patches ☐ 2 Boxes of 30 Patches	☐ _____
☐ **Licart™** 30 Patches per Box	☐ 1.3% Patch 30 Patches per Box	☐ **Dose:** Apply one patch topically to clean, dry, hairless area once daily. ☐ Other: _____	☐ 1 Box of 30 Patches ☐ 2 Boxes of 60 Patches	☐ _____
☐ _____	☐ _____	☐ _____	☐ _____	☐ _____

PRESCRIBER SIGNATURE: Please sign and date below

Prescriber Authorization: By signing below, I hereby authorize the Pharmacy to submit this info to the patient's insurance company/payor for the prescribed medication, including providing a copy of this completed form for any prior authorization request when allowed by the insurance company.

☐ Dispense as written

Prescriber Signature

Date