Premier Health Plan
Pharmacy Services
Commercial Phone: 855-266-0713
Exchange Phone: 866-822-2413
Fax: 855-862-6518

CELECOXIB
Prior Authorization Form

□ Standard Request □ Expedited Request	If you or your prescriber believe that waiting for a standard decision could seriously harm your life, health, or ability to regain maximum function, you can request an expedited decision. ***For state exchanges only:*** The above disclaimer applies for exigent circumstances. Expedited review may also be requested when you are undergoing a current course of treatment using a non-formulary drug.

Demographics

Patient Information		Prescriber Information	
Patient Name:		Prescriber Name:	
DOB:	Age:	NPI#:	Specialty:
Health Plan ID#:		Phone:	Fax:
Pharmacy Name:	Pharmacy Phone:	Office Contact:	Direct Phone # or Ext:

Medication Information

Medication:	Strength:	Directions:	Quantity Dispensed:	Day Supply:
Celecoxib	□ 50mg Capsule □ 200mg Capsule □ 100mg Capsule □ 400mg Capsule			

□ New medication □ Continuation of therapy	Start Date:	If this is continuation of therapy, please provide CHART DOCUMENTATION indicating the member showed improvement while on therapy.

Clinical Information

Diagnosis:	Date of Diagnosis:

Risk Factors/Medical History

History of GI bleed or ulcer disease?	□ Yes □ No	If Yes, Please Define Type of Ulcer: □ Peptic □ Duodenal □ Gastric
Daily Oral Steroid Use?	□ Yes □ No	If Yes, Please List Medication:
Anticoagulant or antiplatelet use?	□ Yes □ No	If Yes, Please List Medication:
Documented Sulfa Drug Allergy?	□ Yes □ No	If Yes, Have Samples Been Given *WITHOUT* REACTION? □ Yes □ No
Comorbid Conditions	□CHF □Renal Failure □Bleeding disorder □ Other:_____	

History of Formulary Medications Used To Treat The Above Condition

[i.e. Nonsteroidal Anti-Inflammatory Drugs(NSAIDS)] Please include drug name, strength, date tried, *a reason for failure* of **at least two prescription NSAIDs** such as *ibuprofen 600mg* or *naproxen 500mg*).

History of Medications Used to Treat Above Condition

□ No other medications have been used to treat this condition

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Member Name:	DOB:	Health Plan ID:
Please be sure to complete and include this page with the 1st page of this form.		

Medication	Strength	Directions	Dates of Therapy		Reason for Discontinuing
			Start	End	

Please provide any additional information which should be considered in the space below: