OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
Please note: All information below is required to process this request.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Celebrex® (celecoxib) Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength: / Dosage Form:
❑ Check if requesting **brand**	Directions for Use:
❑ Check if request is for **continuation of therapy**	

Clinical Information (required)

Select the diagnosis below:

- ❑ Acute pain
- ❑ Ankylosing spondylitis
- ❑ Juvenile rheumatoid arthritis
- ❑ Osteoarthritis (OA)
- ❑ Primary dysmenorrhea
- ❑ Rheumatoid arthritis (RA)
- ❑ Other diagnosis: _____ ICD-10 Code(s): _____

Select the medications the patient has had a history of:

❑ Diclofenac potassium	❑ Ibuprofen	❑ Nabumetone
❑ Diclofenac sodium	❑ Indomethacin	❑ Naproxen
❑ Etodolac	❑ Ketoprofen	❑ Oxaprozin
❑ Etodolac ER	❑ Ketorolac	❑ Piroxicam
❑ Fenoprofen	❑ Meclofenamate	❑ Sulindac
❑ Flurbiprofen	❑ Meloxicam	❑ Tolmetin

❑ Other Nonsteroidal Anti-inflammatory Drugs (NSAIDs). Please specify:_____

Quantity limit requests:
What is the quantity requested per DAY? _____

What is the reason for exceeding the plan limitations?

- ❑ Titration or loading dose purposes
- ❑ Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- ❑ Requested strength/dose is not commercially available
- ❑ Other: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.