



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 <small>(required)</small>	Provider Information <small>(required)</small>
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Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information <small>(required)</small>
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Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting brand	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information <small>(required)</small>
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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:

<input type="checkbox"/> Diclofenac potassium	<input type="checkbox"/> Ibuprofen	<input type="checkbox"/> Nabumetone
<input type="checkbox"/> Diclofenac sodium	<input type="checkbox"/> Indomethacin	<input type="checkbox"/> Naproxen
<input type="checkbox"/> Etodolac	<input type="checkbox"/> Ketoprofen	<input type="checkbox"/> Oxaprozin
<input type="checkbox"/> Etodolac ER	<input type="checkbox"/> Ketorolac	<input type="checkbox"/> Piroxicam
<input type="checkbox"/> Fenoprofen	<input type="checkbox"/> Meclofenamate	<input type="checkbox"/> Sulindac
<input type="checkbox"/> Flurbiprofen	<input type="checkbox"/> Meloxicam	<input type="checkbox"/> 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.

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 Office use only: Celebrex-celecoxib_Comm_2018Mar-W