Celebrex® (celecoxib) Prior Authorization Request Form

Member Information (required) | Provider Information (required)
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Member Name: | Provider Name: 
Insurance ID#: | NPI#: 
Date of Birth: | Office Phone: 
Street Address: | Office Fax: 
City: | State: 
Phone: | City: 
Member Information (required)
Medication Name: | Strength: 
Directions for Use: | Dosage Form: 
Select the diagnosis below:
- Acute pain
- Ankylosing spondylitis (AS)
- Juvenile rheumatoid arthritis
- Other diagnosis: ___________________ 
ICD-10 Code(s): __________ 
Select the medications the patient has a failure, contraindication, or intolerance to:
- Celecoxib
- Diclofenac potassium
- Diclofenac sodium delayed-release (DR)
- Diclofenac sodium extended-release (ER)
- Diflunisal
- Etodolac
- Etodolac ER
- Fenoprofen
- Flurbiprofen
- Ibu
- Ibuprofen
- Ketoprofen
- Meofenamate
- Mefenamic acid
- Meloxicam
- Mobic
- Nabumetone
- Nalfon
- Naproxen
- Naproxen DR
- Naproxen sodium
- Naproxen sodium ER
- Profeno
- Sulindac
- Tolmetin
- Vivlodex

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

What is the reason for exceeding the plan limitations?

Select the medications the 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

There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. Please specify: ________________________________

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.
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.
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.

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.
Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific