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

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
- ❑ EC-Naprosyn
- ❑ Etodolac
- ❑ Etodolac ER
- ❑ Fenoprofen
- ❑ Flurbiprofen
- ❑ Ibu
- ❑ Ibuprofen
- ❑ Ketoprofen
- ❑ Meclofenamate
- ❑ Mefenamic acid
- ❑ Meloxicam
- ❑ Mobic
- ❑ Nabumetone
- ❑ Nalfon
- ❑ Naproxen
- ❑ Naproxen DR
- ❑ Naproxen sodium
- ❑ Naproxen sodium ER
- ❑ Ponstel
- ❑ Profeno
- ❑ Sulindac
- ❑ Tolmetin
- ❑ Vivlodex

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
- ❑ 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.