PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Celebrex® (celecoxib)

HEALTH PARTNERS
In Wellness and Health, Partners for Life.

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please print clearly.**

Patient Name:	**Physician Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic. Id:
Address:	Address:	
City, State, Zip:	City, State, Zip:	

Drug Name: Expedited/Urgent

Directions:

Please answer the following questions and sign below:

Q1. What is the requested duration of therapy?

- 12 months or less
- Greater than 12 months

Q2. What is the patient's diagnosis?

- Osteoarthritis
- Acute pain
- Primary Dysmenorrhea
- Rheumatoid Arthritis
- Juvenile Rheumatoid Arthritis
- Ankylosing Spondylitis
- Familial Adenomatous Polyposis
- Other

Q3. What risk factors to on-going NSAID therapy does the patient have?

- Patient is 60 years of age or greater (except for juvenile rheumatoid arthritis)
- Previous clinical history of gastroduodenal ulcer, gastrointestinal bleeding, or gastroduodenal perforation, coagulation defect, erosive esophagitis
- Concomitant use of chronic systemic corticosteroids, anticoagulants, or Plavix®
- Not Applicable

Q4. Is the patient currently taking any other NSAID other than low dose aspirin?

Yes No

Q5. Is the prescribed dosage of Celebrex consistent with the FDA-approved manufacturer labeling?

Yes No

Q6. Does the patient have a history of treatment failure or intolerance to at least 2 (TWO) formulary NSAIDS?

Yes No

Physician Signature **Date**

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