

Pharmacy

PRIOR AUTHORIZATION FORM

For Prior Authorization, please fax to: (877) 974-4411 toll free, or (616) 942-8206

This form applies to: Commercial Plan Medicaid Plan Medicare Plan

Celebrex[®] (celecoxib)

URGENT (life threatening)

Non-Urgent (standard review)

A claim involving "urgent care" applies when the standard review time will seriously jeopardize the life or health of the member, or subject the member to severe pain that cannot be managed without the care or treatment requested in the subject of this request. **Priority Health averages between 1 and 3 business days for our standard review response time.**

Member Information

Member Name:	Member No.:
DOB:	Gender:
Member's PCP:	

Provider Information

Provider Name:	
Office Contact Name:	Provider Phone:
Provider NPI:	Provider Fax:
Provider Address:	

Provider Signature

Date

PRODUCT INFORMATION

Strength:		Frequency:		Start date: _____
<input type="checkbox"/> Celebrex 50mg	<input type="checkbox"/> Celebrex 200mg	<input type="checkbox"/> once daily		Patient's Age: _____
<input type="checkbox"/> Celebrex 100mg	<input type="checkbox"/> Celebrex 400mg	<input type="checkbox"/> twice daily		

PRIORITY HEALTH PRECERTIFICATION REQUIREMENTS

Authorization for Celebrex[®] (celecoxib) requires the following information to certify:

Patient must have met the following requirements:

- Diagnosis of osteoarthritis, rheumatoid arthritis, juvenile rheumatoid arthritis, ankylosing spondylitis, familial adenomatous polyposis, dysmenorrhea, or acute pain in adults.
- Patient must have one of the following:
 - A major NSAID-induced GI complication risk factor such as active bleed or bleeding disorder, current anticoagulant therapy (other than aspirin), previous history of an ulcer or GI bleed, or chronic, systemic corticosteroid therapy
 - Documented therapeutic trial and clinical failure with at least two of the following formulary alternatives: Mobic (meloxicam), Lodine (etodolac), Relafen (nabumetone), and Voltaren (diclofenac sodium)
- A patient receiving PPI therapy must have one of the following:
 - History of previous GI bleed
 - A major NSAID-induced GI complication risk factor (other than previous GI bleed) **and** a trial and failure with combination NSAID and PPI therapy

PRIORITY HEALTH PRECERTIFICATION DOCUMENTATION
Authorization for Celebrex[®] (celecoxib) requires the following information to certify:
A. What is the patient's diagnosis?

- a. acute pain in adults
- b. ankylosing spondylitis
- c. dysmenorrhea
- d. juvenile rheumatoid arthritis
- e. osteoarthritis
- f. post orthopedic surgery (up to 7 day supply does not require authorization for Orthopedists)
- g. rheumatoid arthritis
- h. *other diagnosis:* _____

rationale for use: _____

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) must be recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only).

B. Is the patient taking a proton pump inhibitor (PPI), including AcipHex, Dexilant, Nexium, Prevacid, Prilosec, Protonix, or Zegerid?

- Yes, patient is currently taking a PPI (patient must also have at least 1 GI risk factor, see question C)
 If yes, has the patient had a trial with combination NSAID and PPI therapy?
 - Yes
 - No (a trial with combination NSAID and PPI therapy required unless patient has history of GI bleed)
- No (patient is not taking a PPI)

C. Which of the following NSAID GI risk factors does the patient have?

- Active bleeding or documented bleeding disorder
- History GI bleeding or ulcer
- Receiving anticoagulant therapy (other than aspirin)
- Chronic, systemic corticosteroid therapy

- None of the above

Patients with no or low NSAID GI risk and are not taking a PPI, authorization for Celebrex requires a documented therapeutic trial and clinical failure with two of the following formulary alternatives with a low risk of GI side effects: Mobic (meloxicam), Lodine (etodolac), Relafen (nabumetone), and Voltaren (diclofenac sodium).

	Dose	Dates	Outcome
<input type="checkbox"/> Mobic (meloxicam)	_____	_____	_____
<input type="checkbox"/> Lodine (etodolac)	_____	_____	_____
<input type="checkbox"/> Relafen (nabumetone)	_____	_____	_____
<input type="checkbox"/> Voltaren (diclofenac)	_____	_____	_____

- Not all requirements are met – Below is rationale for use:

OTHER INFORMATION

- When authorized, coverage duration is for 1 year and limited to 200 mg per day, except for diagnosis of rheumatoid arthritis is limited to 400 mg per day.

FOR MEDICARE ONLY

If none of the above precertification criteria is applicable to this member, please check off which, if any, of the following apply:

1. All covered Part D drugs on any tier of a plan's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects
2. The number of doses available under a dose restriction for the prescription drug:
 - a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
3. The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements:
 - a. Has been ineffective in the treatment of the enrollee's disease or medical condition, or
 - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance.
 - c. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee.
4. None of the above apply

****If you selected 1, 2, or 3 above, supporting evidence/documentation is required for review. If no supporting evidence/documentation is provided, this request will not be approved.**

***** All fields must be complete and legible for Prior Authorization Review***
Please fax this request to: (877)974-4411 toll free or (616)942-8206
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX**