

UPMC HEALTH PLAN

CELEBREX

Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE 800-979-UPMC (8762)

FAX 412-454-7722

THIS SECTION FOR PROVIDER USE ONLY—PLEASE TYPE OR PRINT NEATLY

Please complete all sections of this form AND include details of past relevant medical treatment, which substantiates the need for an exception to using formulary alternatives, i.e. past prescription treatment failures, documented side effects, chart documentation, lab values, etc. Incomplete responses may delay this request.

Office Contact:		Provider Specialty:			
Provider First Name:		Provider Last Name:			
Provider Phone:		Provider Fax:			
Patient Name:		Patient UPMC Health Plan ID Number:		Patient DOB:	Patient Age:
Drug Requested:	Strength:	Frequency:	Qty Dispensed:		
<input type="checkbox"/> Brand <input type="checkbox"/> Generic					
<input type="checkbox"/> New Medication <input type="checkbox"/> Ongoing Medication	If Ongoing Provide Date Started:	If medication is ongoing, Did the member show improvement while on therapy?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Diagnosis:			Date of diagnosis:		
Risk Factors/Medical History:					
History of Ulcer Disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Please Define Type of Ulcer: <input type="checkbox"/> Peptic <input type="checkbox"/> Duodenal <input type="checkbox"/> Gastric		
Daily Oral Steroid Use?	<input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Please List Medication:		
Anticoagulant Use?	<input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Please List Medication:		
Documented Sulfa Drug Allergy (for Celebrex requests) ?	<input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Have Samples Been Given WITHOUT REACTION? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Comorbid Condition, CHF, Renal Failure, Etc.?	<input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, Please List Comorbid Condition(s):		
History of Formulary Medications Used To Treat The Above Condition [i.e. Nonsteroidal Anti-Inflammatory Drugs (NSAIDS)] please include drug name, strength, date tried, a reason for failure of at least two prescription NSAIDs such as <i>ibuprofen 600mg</i> or <i>naproxen 500mg</i> .					
Medication Trial/ Previous Therapy	Date of Therapy Start Date End Date		Strength	Frequency	List Adverse Reactions/Side Effects/ Reason For Discontinuing