

# 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

### 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:   |                    | Provider NPI #:              |
| 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 |   |                    |                              |
| <i>Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.</i> |                                  |   |                    |                              |
| <input type="checkbox"/> New 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"/> Ongoing Medication  |                                  |   |                    | <input type="checkbox"/> No  |
| Diagnosis  |                                  |   | Date of diagnosis: |                              |

### Risk Factors/Medical History:

|   |   |  |  |  |
|---|---|--|--|--|
| History of Ulcer Disease?                     | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | If Yes, Please Define Type of Ulcer:<br><input type="checkbox"/> Peptic <input type="checkbox"/> Duodenal <input type="checkbox"/> Gastric |  |  |
| Daily Oral Steroid Use?                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | If Yes, Please List Medication:  |  |  |
| Anticoagulant Use?                            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | If Yes, Please List Medication:  |  |  |
| Documented Sulfa Drug Allergy?                | <input type="checkbox"/> Yes<br><input type="checkbox"/> No | If Yes, Have Samples Been Given <u>WITHOUT</u> REACTION?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                       |  |  |
| Comorbid Condition, CHF, Renal Failure, Etc.? | <input type="checkbox"/> Yes<br><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 *ibuprofen 600mg* or *naproxen 500mg*).

| Medication Trial/Previous Therapy | Date of Therapy |          | Strength | Frequency | List adverse reactions/side effects/ reason for discontinuing |
|-----------------------------------|-----------------|----------|----------|-----------|---|
|                                   | Start Date      | End Date |          |           |   |
|                                   |                 |          |          |           |   |

Please provide any additional information which should be considered in the space below:

|  |
|--|
|  |
|  |
|  |