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: ❑ Brand ❑ Generic	**Strength:**	**Frequency:**	**Qty Dispensed:**

Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.

❑ New Medication ❑ Ongoing Medication	**If Ongoing Provide Date Started:**	**If medication is ongoing, Did the member show improvement while on therapy?**	❑Yes ❑No
Diagnosis		**Date of diagnosis:**	

Risk Factors/Medical History:

History of Ulcer Disease?	❑ Yes ❑ No	**If Yes, Please Define Type of Ulcer:** ❑ Peptic ❑ Duodenal ❑ Gastric
Daily Oral Steroid Use?	❑ Yes ❑ No	**If Yes, Please List Medication:**
Anticoagulant Use?	❑ Yes ❑ No	**If Yes, Please List Medication:**
Documented Sulfa Drug Allergy?	❑ Yes ❑ No	**If Yes, Have Samples Been Given <u>WITHOUT</u> REACTION?** ❑ Yes ❑ No
Comorbid Condition, CHF, Renal Failure, Etc.?	❑ Yes ❑ 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 Start Date End Date	Strength	Frequency	List adverse reactions/side effects/ reason for discontinuing

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