UnitedHealthcare
Community Plan

CELEBREX

PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

Today's Date

SECTION A - PATIENT INFORMATION

First Name:	Last Name:	Member ID:
Address:		
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW ☐ or a CONTINUATION of THERAPY☐? If so, start date:______________________

Is this patient currently hospitalized? ☐Yes ☐No

SECTION B - PHYSICIAN INFORMATION

First Name:		Last Name: M.D./D.O.		
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

SECTION C - MEDICAL INFORMATION

Medication: **Strength:**

Directions for use:

Diagnosis (Please be specific & provide as much information as possible)**:** **ICD-9 CODE:**

- Is this a new prescription for the patient or a continuation of existing therapy?
- Does the patient have a confirmed diagnosis of familial adenomatous polyposis (FAP)?
- Has the patient had inadequate pain relief when treated with at least three formulary non-steroidal anti-inflammatory drugs (NSAIDs) in the previous three months? *(Please list in the table below).*
- Does the patient have a previous clinical history of gastrointestinal (GI) ulcer, GI bleeding, or GI perforation?
- Is the patient currently using chronic systemic corticosteroids (i.e. prednisone)?
- Is the patient currently taking anticoagulants (i.e. Coumadin, Warfarin, Jantoven, Lovenox, Fragmin, Arixtra, Heparin) or anti-platelet agents (excluding aspirin) (i.e. Plavix, Aggrenox, Effient, ticlopidine, cilostazol)?

Explanation of why the preferred medication(s) would not meet your patient's needs:

Other Medications tried

Medications	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Physician Signature: ____ Date: ___________________

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