PRIOR AUTHORIZATION REQUEST

Celecoxib

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Does the patient have a history of non-steroidal anti-inflammatory (NSAID)-induced gastritis that was confirmed by esophagogastroduodenoscopy (EGD)? [If yes, skip to question 5.]	Yes	No
2	Is the patient at a high-risk for adverse gastrointestinal events: A) Age 65 years or older, B) History of gastrointestinal (GI) ulcer, GI bleeding or non-steroidal anti-inflammatory (NSAID)-induced gastritis, OR C) Currently taking corticosteroids (i.e., prednisone) or anticoagulants (i.e., warfarin, enoxaparin)? [If no, skip to question 4.]	Yes	No

If you have any questions, call: 1-888-258-8250

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3	Is the patient taking a daily aspirin? [If yes, no further questions.] [If no, skip to question 5.]	Yes	No
4	Has the patient had inadequate pain relief with at least 3 formulary non-steroidal anti-inflammatory drugs (NSAIDs)? [NOTE: Formulary NSAIDs include the following as prescription or over-the-counter (OTC): IBUPROFEN, NAPROXEN SODIUM, DICLOFENAC, ETODOLAC, KETOPROFEN, MELOXICAM, NABUMETONE, OXAPROZIN, PIROXICAM.] [If no, no further questions.]	Yes	No
5	Does the patient have a diagnosis of juvenile rheumatoid arthritis (JRA) AND is at least 2 years of age? [NOTE: Dosing for patients greater than 25 kg is 100 mg twice daily; patients 10-25 kg dosing is 50 mg twice daily.] [If yes, no further questions.]	Yes	No
6	Did the patient have a recent (within the past 14 days) coronary artery bypass surgery (CABG)? [If yes, no further questions.]	Yes	No
7	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
8	Does the patient have a diagnosis of Osteoarthritis (OA)? [NOTE: Please note the dose limit for OA is 200 mg/day.] [If yes, no further questions.]	Yes	No
9	Does the patient have one of the following diagnoses: A) Rheumatoid arthritis (RA), B) Ankylosing spondylitis, C) Moderate to severe pain associated with orthopedic surgery, D) Psoriatic arthritis, E) Acute Pain, F) Primary dysmenorrhea? [NOTE: Please note the dose limit is 400 mg/day.]	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

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Version 07.2025

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Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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