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	Is this request for INITIAL or CONTINUATION of therapy with the requested medication? [] Initial (If checked, go to 7) [] Continuation (If checked, go to 2)		
2	Is the patient currently receiving the requested medication? [If no, skip to question 7.]	Yes	No

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

Version 07.2026

PRIOR AUTHORIZATION REQUEST

3	Has the patient been receiving medication samples of the requested medication? [If yes, skip to question 7.]	Yes	No
4	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 7.]	Yes	No
5	Has the patient been established on therapy for at least 3 months? [If no, skip to question 7.]	Yes	No
6	Has documentation been submitted to confirm that the patient has had a clinically significant response to therapy, as determined by the provider? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
7	What is the indication or diagnosis? [] Juvenile rheumatoid arthritis (JRA) (If checked, go to 8) [] Osteoarthritis (If checked, go to 14) [] Rheumatoid arthritis (If checked, go to 14) [] Ankylosing spondylitis (If checked, go to 14) [] Moderate to severe pain associated with orthopedic surgery (If checked, go to 14) [] Psoriatic arthritis (If checked, go to 14) [] Acute pain (If checked, go to 14) [] Primary dysmenorrhea (If checked, go to 14) [] Other (If checked, no further questions)		
8	Does the patient have a diagnosis of juvenile rheumatoid arthritis (JRA) AND is at least 2 years of age? [If no, no further questions.]	Yes	No
9	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 11.]	Yes	No

PRIOR AUTHORIZATION REQUEST

10	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 12.]	Yes	No
11	Is the patient taking a daily aspirin? [If yes, no further questions.] [If no, skip to question 13.]	Yes	No
12	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
13	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? [Note: Dosing: A) Juvenile rheumatoid arthritis (JRA): dosing for patients greater than 25 kg is 100 mg twice daily; dosing for patients 10 kg to 25 kg is 50 mg twice daily, B) Osteoarthritis (OA): dose limit is 200 mg/day, C) Rheumatoid arthritis (RA): dose limit is 400 mg/day, D) Ankylosing spondylitis: dose limit is 400 mg/day, E) Moderate to severe pain associated with orthopedic surgery: dose limit is 400 mg/day, F) Psoriatic arthritis: dose limit is 400 mg/day, G) Acute Pain: dose limit is 400 mg/day, H) Primary dysmenorrhea: dose limit is 400 mg/day.] [No further questions.]	Yes	No
14	Is the patient greater than or equal to 18 years of age? [If no, no further questions.]	Yes	No
15	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 19.]	Yes	No
16	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 18.]	Yes	No
17	Is the patient taking a daily aspirin? [If yes, no further questions.] [If no, skip to question 19.]	Yes	No
18	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

maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

19	Did the patient have a recent (within the past 14 days) coronary artery bypass surgery (CABG)? [If yes, no further questions.]	Yes	No
20	Does the requested dose exceed Food and Drug Administration (FDA) approved label dosing for the requested indication? [Note: Dosing: A) Juvenile rheumatoid arthritis (JRA): dosing for patients greater than 25 kg is 100 mg twice daily; dosing for patients 10 kg to 25 kg is 50 mg twice daily, B) Osteoarthritis (OA): dose limit is 200 mg/day, C) Rheumatoid arthritis (RA): dose limit is 400 mg/day, D) Ankylosing spondylitis: dose limit is 400 mg/day, E) Moderate to severe pain associated with orthopedic surgery: dose limit is 400 mg/day, F) Psoriatic arthritis: dose limit is 400 mg/day, G) Acute Pain: dose limit is 400 mg/day, G) Acute Pain: dose limit is 400 mg/day, F) Primary dysmenorrhea: 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

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.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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