Prior Authorization Form

Celebrex® (celecoxib), **Mobic®** (meloxicam), **Ultram ER®** (tramadol ER)

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: *(check one)* ☐ **Celebrex®** ☐ **Mobic®** ☐ **Ultram ER®**

Date: ____________________ Patient ID#: ____________ DOB:__________

Patient Name: ______________________ Provider NPI: ______________________

Prescribing Physician: __________________ Office Contact: ______________________

Office Fax #: ______________________ Office Phone: ______________________

ONLY COMPLETED REQUESTS WILL BE REVIEWED

1. DIAGNOSIS FOR DRUG REQUESTED:

☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ Familial Adenomatous Polyposis (FAP)
☐ Other (specify)______________________

2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

☐ **N/A** If none or not applicable to diagnosis, indicate "N/A."

Drug Name	Date	Duration

3. PATIENT HISTORY: (Celebrex and Mobic only)

a. Does the patient have sulfonamide allergy? ☐ Yes ☐ No
(Sulfa allergy is exclusionary for Celebrex and that documentation of tolerating a trial of these agents would be required for approval).

b. Does the patient have NSAIDs or aspirin allergy (i.e. ibuprofen, naproxen)? ☐ Yes ☐ No

c. Is the patient currently on an anticoagulant (i.e. warfarin) within the last 90 days? ☐ Yes ☐ No

d. Does the patient have any bleeding disorder? ☐ Yes ☐ No

e. Is the patient currently on any concurrent systemic steroid treatment? ☐ Yes ☐ No

f. Does the patient have a history of gastrointestinal bleed, peptic ulcer, GERD, or Barretts esophagus? ☐ Yes ☐ No

Please add any other supporting medical information that may be useful in the decision-making process:

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FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal use only | **Coverage effective date** / /
Document #______________ | Processor Initials__________ | Date______________
M F Rx coverage Y N | STANDARD - SELECT | LOB______________
Previous Auth Y N | **Approved** | **Reviewer Initials**__________ | Date__________

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