AmeriHealth

Prior Authorization Form

Celebrex, Mobic, Ultram ER, Flector patch, Voltaren gel, Ryzolt, Zipsor

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: *(check one)*

☐ **Voltaren gel®** ☐ **Celebrex®** ☐ **Mobic®** ☐ **Ultram ER®** ☐ **Flector patch®** ☐ **Ryzolt®**

☐ **Zipsor®**

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 ☐ N/A
(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 ☐ N/A

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

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

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

f. Does the patient have a history of gastrointestinal bleed, peptic ulcer, GERD, or Barrett's esophagus? ☐ Yes ☐ No ☐ N/A

Please add any other supporting medical information that may be useful in the decision-making process including contraindications to medications related to the diagnosis:

_____

_____

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