FORM # FRX018

Prior Authorization Request Form for Celebrex (celecoxib)

Member Information

Patient Name ____________________________

Cardholder ID ____________________________

Date of Birth ____________________________

Address ____________________________

City, State Zip ____________________________

Phone Number ____________________________

Provider Information

Provider Name ____________________________

DEA Number ____________________________

Address ____________________________

City, State and Zip ____________________________

Phone Number ____________________________

FAX Number ____________________________

Pharmacy Information

Pharmacy Name___________________Address__________________Phone______________________

Criteria for Approval:

1. **Celebrex** ☐ **100mg** ☐ **200mg**
2. Is the patient between 18 years of age and 60 years of age? Yes☐ No☐
3. Is the patient 60 years of age or older? Yes☐ No☐
4. Does the patient have any of the following diagnoses? *Check all that apply:*
   ☐ Familial adenomatous polyposis (FAP) ☐ Primary dysmenorrhea
   ☐ Acute pain ☐ Osteoarthritis ☐ Rheumatoid arthritis
5. Is the patient at high risk for NSAID-induced gastrointestinal (GI) adverse events? Yes☐ No☐
6. Is the patient currently on a proton pump inhibitor? Yes☐ No☐
7. Is the patient currently on aspirin therapy? Yes☐ No☐
8. Has the patient experience any allergic reaction to taking any of the following?
   Check all that apply:
   ☐ Aspirin ☐ NSAIDs ☐ Sulfonamides

Provider Signature ____ Date _______________________

Fax completed forms to (866) 284-4509.

For Office Use Only

Date/Time Received____

Reference Number____

Approved / Denied (Circle One) by _____________________________ Date_______________________

Date/Time Returned to Provider____

If you have any questions regarding this form, contact the Prior Authorization Department Toll Free at (866) 284-4492 or Fax Toll Free at (866) 284-4509.

FOX Rx Care Utilization Management
3375-I Capital Circle NE
Tallahassee, FL 32308

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