



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® [] Flector patch®
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."

Table with 3 columns: Drug Name, Date, Duration. Includes horizontal lines for data entry.

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:

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 _____