



Prior Authorization Form

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

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: (check one)

- Checkboxes for 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:

- Checkboxes for Osteoarthritis, Rheumatoid arthritis, Familial Adenomatous Polyposis (FAP), Other

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 columns: Drug Name, Date, Duration

3. PATIENT HISTORY: (Celebrex and Mobic only)

- a. Does the patient have sulfonamide allergy?
b. Does the patient have NSAIDs or aspirin allergy...
c. Is the patient currently on an anticoagulant...
d. Does the patient have any bleeding disorder?
e. Is the patient currently on any concurrent systemic steroid treatment?
f. Does the patient have a history of gastrointestinal bleed, peptic ulcer, GERD, or Barrett's esophagus?

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.