OPTIMA FAMILY CARE MEDALLION 4.0

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: ***The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete forms will delay authorization process.***

Drug Requested: **Celebrex®** (celecoxib) ***(MEDICAID ONLY)***

[Non-Preferred Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)]

DRUG INFORMATION*: *Complete all information below or authorization process will be delayed.

Drug Form: _____ **Strength:** _____

Dosing Frequency: _____ **Length of Therapy**: _____

Diagnosis: _____ ***ICD Code, if applicable:*** _____

MEDICAL INFORMATION*: *Check box that applies to ensure authorization will NOT be delayed.

❑ Patient has tried and failed two (2) different non-COX2 NSAIDs within the past year ❑ Yes ❑ No

OR

❑ Concurrent use of anticoagulants (i.e., warfarin, heparin, etc.), methotrexate, oral corticosteroids; ❑ Yes ❑ No

OR

❑ History of previous GI bleed or conditions associated with GI toxicity risk factors *(i.e., PUD, GERD, etc.)*; ❑ Yes ❑No

OR

❑ Specific indication for Celebrex® for which preferred drugs are ***not*** indicated. Please list drugs tried and failed.

_____

_____

****Use of samples to initiate therapy does not meet step-edit/preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

REVISED/UPDATED: 7/1/2018