Texas | Medicaid • Medicare Advantage

Wellpoint

# Celebrex Prior Authorization of Benefits Form

**CONTAINS CONFIDENTIAL PATIENT INFORMATION**
**Complete form in its entirety and fax to: Prior Authorization of Benefits Center at 1-844-474-3341.**

| 1. Patient information | 2. Physician information |
|---|---|
| Patient name: _____ | Prescribing physician: _____ |
| Patient ID #: _____ | Physician address: _____ |
| Patient DOB: _____ | Physician phone #: _____ |
| Date of Rx: _____ | Physician fax #: _____ |
| Patient phone #: _____ | Physician specialty: _____ |
| Patient email address: _____ | Physician DEA: _____ |
| | Physician NPI #: _____ |
| | Physician email address: _____ |

| 3. Medication | 4. Strength | 5. Directions | 6. Quantity per 30 days |
|---|---|---|---|
| Celebrex | ☐ 50mg ☐ 100mg ☐ 200mg ☐ 400mg | _____ | Specify: _____ |

**7. Diagnosis:** _____

**8. Approval criteria:** (Check all boxes that apply. Note: Any areas not filled out are considered not applicable to your patient and may affect the outcome of this request.)

Patient's age: _____

☐ Yes ☐ No Patient has a diagnosis of FAP or ankylosing spondylitis in the last 730 days.
☐ Yes ☐ No Patient has a diagnosis of PUD or GI bleed in the last 730 days.
☐ Yes ☐ No Patient has a history of warfarin therapy for 30 days in the last 45 days.
☐ Yes ☐ No Patient has a history of corticosteroid therapy for greater than or equal to 35 days in the last 90 days.
☐ Yes ☐ No Patient has taken high dose NSAID therapy for 30 days in the last 45 days.
☐ Yes ☐ No Patient has a diagnosis of RA, JRA, or OA in the last 730 days.
☐ Yes ☐ No Patient has a history of a DMARD agent for 30 days in the last 60 days.





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|---|
| ☐ Yes ☐ No Patient has a history of 2 or more NSAID agents for 30 days in the last 180 days<br>☐ Yes ☐ No Patient has failed a 30-day treatment trial with at least 1 preferred agent(s) within the past 180 days.<br>☐ Yes ☐ No Patient has a documented allergy or contraindication to preferred agents in this class. |
| ☐ Yes ☐ No Patient is being treated for stage-four advanced, metastatic cancer and associated conditions. |
| For the *Texas Medicaid Preferred Drug List*, please refer to the Texas Medicaid Vendor Drug Program website at https://www.txvendordrug.com/formulary/prior-authorization/preferred-drugs. |

**9. Physician signature**

| |
|---|
| _____ _____<br>Prescriber or authorized signature Date |
| *Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations and exclusions. The submitting provider certifies that the information provided is true, accurate and complete and the requested services are medically indicated and necessary to the health of the patient.*<br>Note: Payment is subject to member eligibility. Authorization does not guarantee payment. |
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