CHORUS COMMUNITY HEALTH PLANS

Prior Authorization Form: Celecoxib (*Celebrex*)

If this is an urgent request, please call Chorus Community Health Plans Pharmacy Services.
Otherwise, please return completed form – Phone: 844-201-4677 or Fax: 844-201-4675

Please type or print neatly ***Incomplete responses may delay this request.***				
Office contact:		Provider specialty:		
Provider first name:		Provider last name:		
Provider phone #:	Provider fax #:		Provider NPI #:	
Patient name:	CCHP Member ID #:		Patient DOB:	Patient age:
Drug requested: **Brand** **Generic**	Strength:	Frequency:	Quantity dispensed (including units):	

Generic equivalent drugs will be substituted for brand name drugs unless you specifically indicate otherwise.

New medication **Ongoing medication**	If ongoing, please provide start date:	If ongoing, did the member show improvement while on therapy?	**Yes** **No**

Diagnosis:

Please indicate place of administration:

Physician's Office ☐ **Hospital/Facility** ☐ **Patient Home** ☐ **Other**

Please provide hospital/facility information:
Name: _____
Phone #: _____
Address: _____
_____

Will the drug be: (select one)

☐ **Billed medically using a JCODE**
JCODE: _____
☐ **Billed at a pharmacy**

Risk Factors/Medical History:

History of Ulcer Disease?	**Yes** ☐ **No** ☐	If yes, please define type of ulcer: Peptic ☐ Duodenal ☐ Gastric ☐
Daily Oral Steroid Use?	**Yes** ☐ **No** ☐	If yes, please list medication:
Anticoagulant Use?	**Yes** ☐ **No** ☐	If yes, please list medication:
Documented Sulfa Drug Allergy?	**Yes** ☐ **No** ☐	If yes, have samples been given WITHOUT reaction? Yes ☐ No ☐
Comorbid Condition (CHF, Renal Failure, etc.?)	**Yes** ☐ **No** ☐	If yes, please list comorbid condition(s):

Has the member failed at least two prescription strength Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) to treat their condition? **Yes** ☐ **No** ☐

Please indicate below past NSAIDs used to treat the member's condition:

Medication name	Start date	End date	Strength	Frequency	Reason for failure or discontinuation

Please provide any additional information which should be considered in the space below: