



NC DMA Pharmacy Request for Prior Approval - Celebrex



Recipient Information

DMA-0029 (V.01)

1. Recipient Last Name: _____ 2. First Name: _____
 3. Recipient ID #: _____ 4. Recipient Date of Birth: _____ 5. Recipient Gender: _____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: Health Choice:

Prescriber Information

7. Prescribing Provider #: _____ NPI: or Atypical:
 8. Prescriber DEA #: _____
 Requester Contact Information
 Name: _____ Phone #: _____ Ext: _____

Drug Information

9. Drug Name: **Celebrex** 10. Strength: _____ 11. Quantity Per 30 Days: _____
 12. Length of Therapy (in days): up to 30 60 90 120 180 Other: _____

Clinical Information

1. Is the patient being treated for pain (acute or chronic)? Yes No
 2. Does the patient have a documented history of GI Bleed, Gastric Ulcer, or Duodenal Ulcer? Yes No
 3. Is the patient receiving a systemic (oral or parenteral) corticosteroid? Yes No
 4. Does the patient have a history of Platelet Dysfunction or Coagulopathy? Yes No
 5. Does the patient have a diagnosis of Familial Adenomatous Polyposis (FAP)? Yes No
 6. Does the patient have a previous intolerance to at least 2 non-COX 2 classes of NSAIDs at therapeutic doses? Yes No

Signature of Prescriber: _____ Date: _____

***Prescriber signature mandatory**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to CSC at: (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505