

SENTARA COMMUNITY PLAN (MEDICAID)

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. If the information provided is not complete, correct, or legible, the authorization process can be delayed.

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

Drug Requested: (check box below that applies)

<input type="checkbox"/> Celebrex [®] (celecoxib)	<input type="checkbox"/> Vyscoxa [™] (celecoxib)
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MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

Weight (if applicable): _____ Date weight obtained: _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ☐ Member 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

(Continued on next page)

- ☐ 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[®], celecoxib, and Vyscoxa[™] 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.****