05/30/2014

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Celebrex (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois Medicaid at **1-855-684-5250**.
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Celebrex (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Celebrex (celecoxib)

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Does the patient have a diagnosis of Juvenile rheumatoid arthritis (JRA)? Y N

   [If no, then skip to question 3.]

2. Is the patient at least 2 years old? Y N

   [If no, then no further questions.]

   [If yes, then skip to question 4.]

3. Is the patient at least 18 years old? Y N

   [If no, then no further questions.]

4. Does patient meet one of the following? Patient had a trial and failure of 2 formulary NSAIDs (e.g. ibuprofen, naproxen, nabumetone, meloxicam, etodolac, diclofenac and others.) Patient has a documented contraindication to use of NSAIDs\ If yes, please document NSAID agents tried and reason for treatment failure OR contraindication to NSAID use: Y N

   _____

   [If yes, then no further questions.]

5. Is the patient at a high-risk for adverse gastrointestinal events (e.g., 65 years of age or older, history of GI bleed, PUD, GERD, or gastritis, or concomitant corticosteroid or anticoagulant use)? Y N

Comments:

_____

_____

I affirm that the information given on this form is true and accurate as of this date.

_____

Prescriber (Or Authorized) Signature Date