Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Celecoxib (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 at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of Celecoxib (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

(celecoxib)

Other, please specify_____

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: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Does the patient have a history of NSAID-induced gastritis that was confirmed by EGD? Y N

   [If yes, then skip to question 5.]

2. Is the patient at a high-risk for adverse gastrointestinal events: A) Age 65 years or older, B) History of gastrointestinal (GI) ulcer, GI bleeding or NSAID-induced gastritis, C) Currently taking corticosteroids (i.e. prednisone) or anticoagulants (i.e. warfarin, enoxaparin)? Y N

   If yes, please indicate which risk factor: _____

[If no, then skip to question 4.]

3. Is the patient taking a daily aspirin? Y N
   [If no, then skip to question 5]
   [If yes, then no further questions]

4. Has the patient had inadequate pain relief with at least 3 formulary non-steroidal anti-inflammatory drugs (NSAIDs)? Y N

   If yes, please list NSAIDs tried: _____
   [If no, then no further questions.]

5. Does the patient have a diagnosis of Juvenile rheumatoid arthritis (JRA) AND is at least 2 years of age? Y N
   [If no, then skip to question 7.]

6. Does the patient weigh more than 25 kg? Y N
   [No further questions]

7. Did the patient have a recent (within the past 14 days) coronary artery bypass surgery (CABG)? Y N
   [If yes, then no further questions.]

8. Is the patient 18 years of age or older? Y N
   [If no, then no further questions]

9. Does the patient have a diagnosis of Osteoarthritis (OA)? Y N
   [If yes, then no further questions]

10. Does the patient have one of the following diagnoses: 1) Rheumatoid arthritis (RA), B) Ankylosing spondylitis, C) Moderate to severe pain associated with orthopedic surgery, D) Psoriatic arthritis? 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