

Health New England
Medication Request Form (MRF)
Celebrex[®]

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Contacted:
Physician:
Pharmacy:
Patient:

Prior Authorization

DO NOT WRITE IN BLOCKED AREAS FOR INTERNAL USE ONLY
Approved:
Quantity approved:
PA from and thru date:
PA #
Denied:
Returned:

Instructions:

This form is to be used by participating physicians and pharmacy providers to obtain coverage of Celebrex. Please complete this form and fax to MedMetrics Health Partners at **(800) 550-9246**. If you have any questions regarding this process, please contact MedMetrics clinical call center at **(866) 209-1057**.

Medication Request Information (please complete each section of this form prior to transmittal):

Patient Information (all required)	Physician Information (all required)
Patient Name :	Physician Name:
	Specialty:
	NPI #:
Patient HNE ID#:	HNE Provider #:
Patient Date of Birth:	DEA #:
Allergies:	Area Code and Telephone #: () -
Diagnosis:	Area Code and Fax # (required): () -

Drug Information

Requested Drug / Strength Celebrex [®] (celecoxib, formulary)			
Dose, directions and length of treatment (please be specific):		Quantity (per month):	Refills:
Physician signature:		Date:	
<i>Check other drugs tried and failed</i>			
<input type="checkbox"/> Anaprox (naproxen sodium)	<input type="checkbox"/> Daypro (oxaprozin)	<input type="checkbox"/> Motrin (ibuprofen)	<input type="checkbox"/> Relafen (nabumetone)
<input type="checkbox"/> Ansaid (flurbiprofen)	<input type="checkbox"/> Feldene (piroxicam)	<input type="checkbox"/> Naprosyn (naproxen)	<input type="checkbox"/> Tolectin (tolmetin)
<input type="checkbox"/> Cataflam (diclofenac)	<input type="checkbox"/> Indocin (indomethacin)	<input type="checkbox"/> Oruvail (ketoprofen)	<input type="checkbox"/> Voltaren (diclofenac)
<input type="checkbox"/> Clinoril (sulindac)	<input type="checkbox"/> Lodine (etodolac)	<input type="checkbox"/> Orudis (ketoprofen)	<input type="checkbox"/> Other (please specify):
<i>Check Co-Morbid Conditions or Co-Therapies that exist:</i>			
<input type="checkbox"/> Age greater than or equal to 65		<input type="checkbox"/> Previous use of at least two (2) NSAIDs tried and failed <i>(please document above)</i>	
<input type="checkbox"/> Previous and/or current history of peptic ulcer or GI bleeds (not dyspepsia, nausea, diarrhea or abdominal pain)		<input type="checkbox"/> High dose NSAID treatment for an extended period of time (2.4gm ibuprofen/day or equivalent for three months or longer)	
<input type="checkbox"/> Corticosteroid Therapy			
<input type="checkbox"/> Anticoagulant Therapy			
<input type="checkbox"/> Alcoholism			
Other Pertinent History (relative or pertaining to this request):			