TEXAS MEDICAID
Clinical Edit Prior Authorization
celecoxib (CELEBREX)

STEP 1: CLEARLY PRINT AND COMPLETE TO EXPEDITE PROCESSING	
Date:	Prescriber First & Last Name:
Patient First & Last Name:	Prescriber NPI:
Patient Address:	Prescriber Address:
Patient ID:	Prescriber Phone:
Patient Date of Birth:	Prescriber Fax:

STEP 2: MEDICATION INFORMATION	
Medication Requested (Name):	Quantity Requested:
Dose Requested:	Dosing Instructions:

Patient's Primary Diagnosis: _____ ICD 10 Code: _____

Please indicate ONE (1) of the following:

☐ STAR / STAR KIDS client **(Go to Step 3 - PDL PA Criteria Applies)**

OR ☐ CHIP / PERINATE client **(Go to Step 4)**

STEP 3: PDL PRIOR AUTHORIZATION CRITERIA FOR NON-PREFERRED PRODUCT

1. Has the client failed a 10-day treatment trial with at least 1 preferred agent in the last 180 days?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #2)

2. Is there a documented allergy or contraindication to preferred agents in this class?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Go to #3)

3. Is the drug necessary for treatment of stage-4 advanced metastatic cancer and associated conditions?

   ☐ Yes (Go to Step 4 Question 1) ☐ No (Deny)

STEP 4: CLINICAL PRIOR AUTHORIZATION CRITERIA

1. Is the client 2 years of age or older?

   ☐ Yes (Go to #2) ☐ No (Deny)

2. Does the client have a diagnosis of Juvenile Rheumatoid Arthritis in the last 730 days?

   ☐ Yes (Approve – 365 days) ☐ No (Go to #3)

3. Is the client 18 years of age or older?

   ☐ Yes (Go to #4) ☐ No (Deny)

4. Is the client 60 years of age or older?

   ☐ Yes (Approve – 365 days) ☐ No (Go to #5)

5. Does the client have a diagnosis of Familial Adenomatous Polyposis (FAP) or Ankylosing Spondylitis in the last 730 days?

   ☐ Yes (Approve – 365 days) ☐ No (Go to #6)

6. Does the client have a diagnosis of Peptic Ulcer Disease (PUD) or GI bleed in the last 730 days?

   ☐ Yes (Approve – 365 days) ☐ No (Go to #7)

7. Does the client have a history of warfarin therapy for 30 days in the last 45 days?

   ☐ Yes (Approve – 365 days) ☐ No (Go to #8)

8. Does the client have corticosteroid therapy for greater than or equal to (≥) 35 days in the last 90 days?

   ☐ Yes (Approve – 365 days) ☐ No (Go to #9)

9. Has the client taken high dose NSAID therapy for 30 days in the last 45 days?

   ☐ Yes (Approve – 365 days) ☐ No (Go to #10)

10. Does the client have a diagnosis of Rheumatoid Arthritis or Osteoarthritis in the last 730 days?

    ☐ Yes (Approve – 365 days) ☐ No (Go to #11)

11. Does the client have a history of a DMARD agent for 30 days in the last 60 days?

    Examples include azathioprine, cyclosporine, hydroxychloroquine, leflunomide, methotrexate, ENBREL, HUMIRA, and KINERET.

    ☐ Yes (Approve - 365 days) ☐ No (Go to #12)

12. Does the client have a history of 2 or more NSAID agents for 30 days in the last 180 days?

☐ Yes (Approve - 365 days) ☐ No (Deny)

STEP 5: SIGN AND FAX TO: NAVITUS PRIOR AUTHORIZATION AT: **855-668-8553**

Prescriber Signature: _____ **Date:** _____

If criteria not met, submit chart documentation with form citing complex medical circumstances.
For questions, please call Navitus Customer Care at 1-877-908-6023.