



Prior Authorization Request Form – NSAID’s/COX-2 Inhibitors

Instructions:

This form is to be used by participating providers to request coverage for NSAID’s or COX-2’s requiring prior authorization. Please fill out this form COMPLETELY, including signature, and fax to MedMetrics Health Partners at 1-800-918-7542. Allow 24 hours to process request. Please call MedMetrics PA Line (available 24 hours a day) at 1-800-918-7550 for more urgent requests.

MedMetrics Health Partners-Prior Authorization Services Phone: 1-800-918-7550
 P. O. Box 2586, Worcester, MA 01606 Fax: 1-800-918-7542

An NSAID/COX-2 step therapy program has been developed to encourage the use of first-line therapies before second-line therapies are used for the same indication. When approved quantity limits may apply.

Please PRINT and complete ALL of the following boxes:

1. Member’s FULL Name:	2. Member’s NHP ID Number:	3. Member’s DOB: (mm/dd/yy)
4. Prescriber’s FULL Name & Specialty:	5. Contact Person at Office:	
6. Prescriber Fax Number & Telephone Number: Fax: () Tel: ()		
Mailing address:		
7. Requested Drug (please check): <input type="checkbox"/> Arthrotec <input type="checkbox"/> Celebrex <input type="checkbox"/> mefenamic acid (Ponstel) <input type="checkbox"/> Zipsor <input type="checkbox"/> Nalfon capsules	8. Does the member have any of the following? <input type="checkbox"/> Concurrent use of Coumadin (warfarin) <input type="checkbox"/> Long term (> than 1 month) use of Oral Corticosteroids <input type="checkbox"/> Previous history of and/or current GI ulcer or bleed <input type="checkbox"/> Platelet dysfunction (reduced counts)/bleeding disorder <input type="checkbox"/> Adenomatous polyposis/attenuated adenomatous polyposis coli	
9. Dose, Frequency, and Duration of Requested Drug:		
10. Is the member currently pregnant or breast feeding? <input type="checkbox"/> Yes <input type="checkbox"/> No		
11. Has the member previously tried the following? (please check all that apply)		
<input type="checkbox"/> Ibuprofen (Motrin)	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response/treatment failure <input type="checkbox"/> allergy
<input type="checkbox"/> Oxaprozin (Daypro)	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response/treatment failure <input type="checkbox"/> allergy
<input type="checkbox"/> Indomethacin (Indocin/SR)	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response/treatment failure <input type="checkbox"/> allergy
<input type="checkbox"/> Fenoprofen (Nalfon) tablets	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response/treatment failure <input type="checkbox"/> allergy
<input type="checkbox"/> Naproxen (Naprosyn, Anaprox, Anaprox DS, Naprelan)	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response/treatment failure <input type="checkbox"/> allergy
<input type="checkbox"/> Ketorolac (Toradol)	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response/treatment failure <input type="checkbox"/> allergy
<input type="checkbox"/> Flurbiprofen (Ansaid)	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response/treatment failure <input type="checkbox"/> allergy
<input type="checkbox"/> Piroxicam (Feldene)	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response/treatment failure <input type="checkbox"/> allergy
<input type="checkbox"/> Diclofenac (Voltaren, Voltaren XR, Cataflam)	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response/treatment failure <input type="checkbox"/> allergy
<input type="checkbox"/> Tolmetin (Tolectin)	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response/treatment failure <input type="checkbox"/> allergy
<input type="checkbox"/> Sulindac (Clinoril)	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response/treatment failure <input type="checkbox"/> allergy
<input type="checkbox"/> Nabumetone (Relafen)	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response/treatment failure <input type="checkbox"/> allergy
<input type="checkbox"/> Etodolac (Lodine, Lodine XL)	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response/treatment failure <input type="checkbox"/> allergy
<input type="checkbox"/> Meclofenamate (Meclomen)	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response/treatment failure <input type="checkbox"/> allergy
<input type="checkbox"/> Ketoprofen (Orudis, Oruvail)	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response/treatment failure <input type="checkbox"/> allergy
<input type="checkbox"/> Meloxicam (Mobic)	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response/treatment failure <input type="checkbox"/> allergy
<input type="checkbox"/> Other (please specify): _____	<input type="checkbox"/> side-effect	<input type="checkbox"/> non-response/treatment failure <input type="checkbox"/> allergy
12. Prescriber comments:		

Signature:

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

 Prescriber’s signature

 Date