

## COX-II Inhibitors

**Submit fax request to:** 855-455-3303

**Purpose:** For a prescribing physician to request prior authorization for a COX-II drug.

**Questions:** If you have questions, call the OptumRx Call Center for Nevada Medicaid at 855-455-3311.

<b>DATE OF REQUEST:</b>		
<b>RECIPIENT INFORMATION</b>		
Last name, First name, Middle initial:		Date of birth:
Recipient ID:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone:
<b>PRESCRIBING PROVIDER INFORMATION</b>		
Name:	NPI:	
Phone:	Fax: (required)	
Person to contact regarding this request:		
<b>DIAGNOSIS AND REQUESTED DRUG</b>		
Name:	Strength:	<input type="checkbox"/> Generic substitution not permitted
Dosage:	Duration:	
Please document the recipient's diagnosis. <i>Check all that apply.</i>		
<input type="checkbox"/> Acute Pain <input type="checkbox"/> Ankylosing Spondylitis <input type="checkbox"/> Bone Pain <input type="checkbox"/> Juvenile Rheumatoid Arthritis <input type="checkbox"/> Osteoarthritis <input type="checkbox"/> Primary Dysmenorrhea <input type="checkbox"/> Rheumatoid Arthritis <input type="checkbox"/> Familial Adenomatous Polyposis (FAP) <input type="checkbox"/> Other (document) _____		
<b>COVERAGE CRITERIA</b>		
<i>Please check the applicable boxes to indicate each item as true for the recipient:</i>		
<input type="checkbox"/> The recipient is at high risk of NSAID-induced adverse gastrointestinal events as evidenced by ANY of the following: <input type="checkbox"/> Recipient has a documented history or presence of peptic ulcer disease <input type="checkbox"/> Recipient has a history or presence of NSAID-related ulcers <input type="checkbox"/> Recipient has a history or presence of clinically significant gastrointestinal bleeding		
<input type="checkbox"/> The recipient is > 65 years of age.		
<input type="checkbox"/> The recipient is at risk for gastrointestinal complications due to concomitant drug therapy with: <input type="checkbox"/> Anticoagulants (e.g., warfarin, heparin, dabigatran or LMW heparin) <input type="checkbox"/> Chronic use of oral corticosteroids		
<input type="checkbox"/> The recipient has a documented history of inability to tolerate at least two non-selective (traditional) NSAIDs.		
<input type="checkbox"/> The recipient is not being treated daily with aspirin for cardioprophylaxis unless concurrent use of a proton pump inhibitor is documented.		
<input type="checkbox"/> The recipient does not have a documented history of cardiac events (i.e., stroke, myocardial infarction, or has undergone a coronary artery bypass graft procedure) in the past six months.		
<input type="checkbox"/> The recipient does not have a history of allergies to sulfonamides, aspirin or other NSAIDs.		
<b>PROVIDER CERTIFICATION</b> – <i>Prescriber's signature and date required.</i>		
<b>I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Nevada Medicaid.</b>		
<b>Prescriber's Signature:</b> _____		<b>Date:</b> _____

*This authorization request is not a guarantee of payment. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program. The information on this form and on accompanying attachments is privileged and confidential and is only for the use of the individual or entities named on this form. If the reader of this form is not the intended recipient or the employee or agent responsible to deliver it to the intended recipient, the reader is hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If this communication is received in error, the reader shall notify sender immediately and destroy all information received.*