Prior Authorization Request

Nevada Medicaid – OptumRx

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.

DATE OF REQUEST:		
RECIPIENT INFORMATION		
Last name, First name, Middle initial:		Date of birth:
Recipient ID:	Gender: ☐ Male ☐ Female	Phone:
PRESCRIBING PROVIDER INFORMATION		
Name:	NPI:	
Phone:	Fax: (required)	
Person to contact regarding this request:		
DIAGNOSIS AND REQUESTED DRUG		
Name:	Strength:	☐ Generic substitution not permitted
Dosage:	Duration:	

Please document the recipient's diagnosis. *Check all that apply.*

☐ Acute Pain ☐ Ankylosing Spondylitis ☐ Bone Pain ☐ Juvenile Rheumatoid Arthritis
☐ Osteoarthritis ☐ Primary Dysmenorrhea ☐ Rheumatoid Arthritis ☐ Familial Adenomatous Polyposis (FAP)
☐ Other (document)_____

COVERAGE CRITERIA

Please check the applicable boxes to indicate each item as true for the recipient:

☐ The recipient is at high risk of NSAID-induced adverse gastrointestinal events as evidenced by ANY of the following:
- ☐ Recipient has a documented history or presence of peptic ulcer disease
- ☐ Recipient has a history or presence of NSAID-related ulcers
- ☐ Recipient has a history or presence of clinically significant gastrointestinal bleeding

☐ The recipient is > 65 years of age.

☐ The recipient is at risk for gastrointestinal complications due to concomitant drug therapy with:
- ☐ Anticoagulants (e.g., warfarin, heparin, dabigatran or LMW heparin)
- ☐ Chronic use of oral corticosteroids

☐ The recipient has a documented history of inability to tolerate at least two non-selective (traditional) NSAIDs.

☐ The recipient is not being treated daily with aspirin for cardioprophylaxis unless concurrent use of a proton pump inhibitor is documented.

☐ 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.

☐ The recipient does not have a history of allergies to sulfonamides, aspirin or other NSAIDs.

PROVIDER CERTIFICATION – *Prescriber's signature and date required.*

I hereby certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Nevada Medicaid.

Prescriber's Signature: _____ **Date:** _____