



Prior Authorization Form

Celebrex, Mobic, Ultram ER, Flector patch, Voltaren gel, Ryzolt, Zipsor

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: (check one)

- Checkboxes for Voltaren gel, Celebrex, Mobic, Ultram ER, Flector patch, Ryzolt, Zipsor

Date, Patient ID#, Patient Name, Prescribing Physician, Office Fax #, Patient ID#, DOB, Provider NPI, Office Contact, Office Phone

ONLY COMPLETED REQUESTS WILL BE REVIEWED

1. DIAGNOSIS FOR DRUG REQUESTED:

- Checkboxes for Osteoarthritis, Rheumatoid arthritis, Familial Adenomatous Polyposis (FAP), Other (specify)

2. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

Check N/A if none or not applicable to diagnosis, indicate "N/A."

Table with columns: Drug Name, Date, Duration

3. PATIENT HISTORY: (Celebrex and Mobic only)

- Questions a-f regarding allergies and medical history with Yes/No/N/A checkboxes

Please add any other supporting medical information that may be useful in the decision-making process including contraindications to medications related to the diagnosis:

Blank lines for additional medical information

FAX: (888) 671-5285 or EMAIL: FSS\_Standard\_Medicare@catalystrx.com
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL