

COX-2 INHIBITOR PRIOR REVIEW FAX REQUEST FORM

PROVIDER INFORMATION		PATIENT INFORMATION
PHYSICIAN NAME	PROVIDER ID/TAX ID	PATIENT NAME
CONTACT PERSON		PATIENT'S BCBSNC ID
PHONE	FAX	PATIENT'S DATE OF BIRTH

COX-2 Inhibitors are considered medically necessary for the treatment of pain and inflammation in patients who meet at least one of the following criteria. **Please indicate either "yes" or "no" to the following:**

1. Age 60 years or greater Yes No
2. History or peptic ulcer disease or NSAID-related ulcer/GI bleeding Yes No
3. Current treatment with anticoagulant, prescription antiplatelet, corticosteroid or DMARD therapy Yes No
4. Hereditary or acquired coagulation defect (e.g., hemophilia, thrombocytopenia, chronic renal failure) Yes No
5. Celecoxib is approved as adjunct therapy for the treatment of Familial Adenomatous Polyposis (FAP). Does this patient have FAP? Yes No
6. Was an adequate trial of at least two non-COX-2, unique/different NSAIDs given at therapeutic doses? Yes No

If so, please list: _____ and _____

Medication Requested: Celebrex

Diagnosis: _____

I certify that, to the best of my knowledge, the information above is accurate.

Prescriber's Signature Required: _____

Fax completed form to 1-800-795-9403

