



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Celebrex (Medicare Prior Authorization)**

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Celebrex (Medicare Prior Authorization).

Drug Name (select from list of drugs shown)

Celebrex 100mg (celecoxib) Celebrex 200mg (celecoxib) Celebrex 400mg (celecoxib)
Celebrex 50mg (celecoxib)

Patient Information

Patient
Name: _____
Patient ID: _____
Patient
Group No.: _____
Patient
DOB: _____

Prescribing Physician

Physician
Name: _____
Physician
Phone: _____
Physician
Fax: _____
Physician
Address: _____
City, State,
Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each applicable question.

- | | | |
|---|---|---|
| 1. Has the patient experienced severe allergic-type reactions after taking aspirin or another NSAID? | Y | N |
| 2. Has the patient experienced severe allergic-type reactions after taking sulfonamides? | Y | N |
| 3. Is the patient at high risk (e.g., >10% 10 year CV event risk by history or cardiac workup) for cardiovascular disease or does the patient have pre-existing cardiovascular disease? | Y | N |
| 4. Is the patient being treated for post-operative pain following CABG surgery? | Y | N |
| 5. Does the patient have a diagnosis of juvenile rheumatoid arthritis (JRA), also referred to as juvenile idiopathic arthritis (JIA)?
[If answer to this question is yes, then skip to question 12.] | Y | N |
| 6. Does the patient have a diagnosis of familial adenomatous polyposis (FAP)?
[If answer to this question is no, then skip to question 8.] | Y | N |
| 7. Will Celebrex be added as an adjunct therapy to the usual care for colorectal polyps?
[No further questions required.] | Y | N |



Arkansas BlueCross BlueShield

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|--|---|---|
| 8. Does the patient have a diagnosis of primary dysmenorrhea?
[If answer to this question is yes, then skip to question 12.] | Y | N |
| 9. Does the patient have a diagnosis of acute pain?
[If answer to this question is yes, then skip to question 12.] | Y | N |
| 10. Does the patient have a diagnosis of osteoarthritis?
[If answer to this question is yes, then skip to question 12.] | Y | N |
| 11. Does the patient have a diagnosis of inflammatory arthritis (e.g.,
rheumatoid, ankylosing spondylitis, etc)? | Y | N |
| 12. Is the patient at risk for an NSAID-related gastrointestinal (GI)
adverse event such as an NSAID associated gastric ulcer or
gastrointestinal bleeding?
(Risk factors may include: Age 60 or older, prior history of GI events [e.g., peptic ulcer, GI bleed,
GERD, S/P gastroectomy, gastritis], or thrombocytopenia or coagulation disorders or concurrent use
of corticosteroids or anticoagulants, Plavix, or chemotherapy or long term or multiple NSAID use.) | Y | N |

Comments: _____

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date