CELEBREX (celecoxib) 400 mg

PRIOR AUTHORIZATION REQUEST FORM

Patient Information	
Name:	Member ID #:
Group Name:	Date of Birth:
Diagnosis:	Diagnosis Code:

Provider Information	
Prescriber's Name:	Prescriber's DEA #:
Phone:	Fax:
Office Address:	

Complete and review information, sign and date. Fax signed form to Caremark's prior authorization department at 1-888-836-0730. The Caremark fax machine is located in a secure location as required by HIPAA regulations. On behalf of the member's health plan, Caremark assists in the administration of the prior authorization program. Caremark is an independent company that administers prescription drug benefits.

Providers may call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures. Members should call Caremark Customer Care at 1-888-963-7290 with any questions. Members may also call their health plan at the number indicated on their Member ID cards.

Please circle the appropriate answer for each applicable question (Y for Yes, N for No).

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 familial adenomatous polyposis (FAP)? Y N

   [If the answer to this question is no, then skip to question 7.]

6. Will Celebrex be added as an adjunct therapy to the usual care for colorectal polyps? Y N

   [No further questions required.]

7. Does the patient have a diagnosis of primary dysmenorrhea? Y N

   [If the answer to this question is yes, no further questions required.]

CELEBREX (celecoxib) 400 mg

PRIOR AUTHORIZATION REQUEST FORM

8. Does the patient have a diagnosis of inflammatory arthritis (e.g., rheumatoid, ankylosing spondylitis, etc.)? Y N

   [If the answer to this question is yes, no further questions required.]

9. Does the patient have a diagnosis of acute pain? Y N

Comments:

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

Prescriber (or Authorized) Signature and Date: