

CELEBREX (celecoxib) QUANTITY MANAGEMENT

PRIOR AUTHORIZATION REQUEST FORM

7. Does the patient have a diagnosis of primary dysmenorrhea? Y N
[If the answer to this question is yes, no further questions required.]
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
10. No further questions required.

Comments:

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

Prescriber (or Authorized) Signature and Date:
