

**Prior Authorization Form**  
**Date Criteria: 06/24/2010**

**CAREFIRST BLUECROSS BLUESHIELD**  
**Celebrex**

**Complete information, sign and date. Fax completed forms to Argus at 1-800-315-4025.**  
**This fax machine is located in a secure location as required by HIPAA regulations.**

**When conditions are met, we will authorize coverage of Celebrex.**  
**Please contact Argus at 1-800-314-2872 with questions regarding the prior authorization process.**

***Patient:***

**Patient Name:** \_\_\_\_\_  
**Patient ID:** \_\_\_\_\_  
**Patient's Group Number:** \_\_\_\_\_  
**Patient's Date of Birth:** \_\_\_\_\_

***Prescribing Physician:***

**Physician Name:** \_\_\_\_\_  
**Physician Phone:** \_\_\_\_\_  
**Physician Fax:** \_\_\_\_\_  
**Prescriber NPI:** \_\_\_\_\_  
**Physician Address:** \_\_\_\_\_  
**Physician City, State, Zip:** \_\_\_\_\_

**Prior Authorization is not required for patients 60 years and older.**  
**Trial and failure of two prescription strength NSAIDs within the past six months is required for consideration of Celebrex.**

1. Is the patient being treated concomitantly with oral corticosteroids, anticoagulants (warfarin or heparin), or antiplatelets (Ticlid, Effient, Plavix or Pletal)?  **Y**  **N**
2. Has the patient tried and failed therapy with two prescription strength nonsteroidal anti-inflammatory drugs (NSAIDs) within the past six months for this condition?  **Y**  **N**  
If yes, please provide the names of the drugs, including strength, dosage and date of trial

Drug/Strength	Dosage	Date of Trial
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Is the patient currently receiving a GI protective agent?  **Y**  **N**
4. Is the patient on concomitant aspirin therapy?  **Y**  **N**

Comments:

\_\_\_\_\_  
*Information given on this form is accurate as of this date.*

\_\_\_\_\_  
**Prescriber or Authorized Signature**

\_\_\_\_\_  
**Date**