

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross[®] BlueShield[®] of South Carolina

Patient Information	
Name:	Insurance ID #:
Address:	Birthdate:

Provider Information	
Physician Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is complete, please fax to Caremark at 888-836-0730.

This fax machine is in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 800-294-5979 with any questions concerning prior authorization procedures.

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 years CV event risk by history or cardiac workshop) 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)? Y N
[If the answer to this question is yes, skip to question 12.]
6. Does the patient have a diagnosis of familial adenomatous polypsis (FAP)? Y N
[If the answer to this question is no, skip to question 8.]
7. Will Celebrex be added as an adjunct therapy to the usual care for colorectal polyps? Y N
[No further questions are required.]
8. Does the patient have a diagnosis of primary dysmenorrhea? Y N
[If the answer to this question is yes, skip to question 12.]

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9. Does the patient have a diagnosis of acute pain?
[If the answer to this question is yes, skip to question 12.] Y N
10. Does the patient have a diagnosis of osteoarthritis?
[If the answer to this question is yes, 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: _____

Information on this form is accurate as of the date below.

Prescriber's Signature:	Date:
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