

Blue Cross Blue Shield of Vermont and The Vermont Health Plan Prior Approval Form

Celebrex® (celecoxib)

BCBSVT and TVHP Fax # (888)–255-1006

If approval criteria are met BCBSVT/TVHP will authorize coverage of Celebrex® (celecoxib).
Thank you for your assistance.

PLEASE COMPLETE THE FOLLOWING SECTIONS:

Date of Request _____ Patient Name: _____
 Member ID#: _____ Date of Birth: _____
 Provider Name: _____ Provider Phone: _____
 Provider Fax: _____ PCP Name: _____

Indicate the regimen being requested:

Strength _____ mg	Quantity _____	Frequency: QD <input type="checkbox"/>	BID <input type="checkbox"/>	Other: _____
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Please Fill in the following information

	YES	NO
1. Is the Patient diagnosed with:		
a. Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
b. Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
c. Dysmenorrhea	<input type="checkbox"/>	<input type="checkbox"/>
d. Ankylosing Spondylitis (AS)	<input type="checkbox"/>	<input type="checkbox"/>
e. Adenomatous colorectal polyps due to familial adenomatous polyposis (FAP)	<input type="checkbox"/>	<input type="checkbox"/>
2. Is Patient 60 years of age or older?	<input type="checkbox"/>	<input type="checkbox"/>
3. Is Patient younger than 18 years of age?	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the patient have a history of hypersensitivity to celecoxib (Celebrex®)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does the patient have a history of hypersensitivity to sulfonamides (sulfa drugs)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the patient have history of cardiovascular disease?	<input type="checkbox"/>	<input type="checkbox"/>
7. Previous Therapy For All DX, including OA:		
Non-steroidal Anti-inflammatory Drugs (NSAIDs)	<input type="checkbox"/>	<input type="checkbox"/>
a. Has patient received a 30 day trial of the following NSAIDs product: <i>(Select all applicable agents, minimum of two in different classes)</i>		
<input type="checkbox"/> diclofenac (Voltaren®/ Arthrotec®)		
<input type="checkbox"/> diflunisal (Dolobid®)		
<input type="checkbox"/> etodolac (Lodine®)		
<input type="checkbox"/> flurbiprofen (Ansaid®)		
<input type="checkbox"/> ibuprofen (Advil®/ Motrin®)		
<input type="checkbox"/> indomethacin (Indocin®)		
<input type="checkbox"/> Disalcid®/salsitab® (salsalate)		
<input type="checkbox"/> Tricosal®/Trilisate® (Magnesium salicylate)		
<input type="checkbox"/> mefenamic acid (Ponstel®)		
<input type="checkbox"/> ketoprofen (Orudis®)		
<input type="checkbox"/> ketorolac (Toradol®)		
<input type="checkbox"/> meloxicam (Mobic®)		
<input type="checkbox"/> nabumetone (Relafen®)		
<input type="checkbox"/> naproxen (Naprosyn® /Anaprox®)		
<input type="checkbox"/> sulindac (Clinoril®)		
<input type="checkbox"/> oxaprozin (Daypro®)		
<input type="checkbox"/> piroxicam (Feldene®)		

Benefit approval: Initial approval: 12 months Renewal approval period: 12 months

PRESCRIBER SIGNATURE _____ DATE _____

By signing above, the prescriber confirms all information provided is accurate and verifiable via member records.