

**COX-2 INHIBITOR  
PREAUTHORIZATION  
PHYSICIAN FAX FORM**



The following documentation is **REQUIRED** for preauthorization. Incomplete forms will be returned for additional information. For formulary information, please visit the Blue Cross and Blue Shield of Nebraska website at [www.bcbsne.com](http://www.bcbsne.com)

Today's Date: \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name (First):	Last:	M.I.:	DOB (mm/dd/yyyy):	Telephone Number:
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**INSURANCE INFORMATION**

BCBS ID Number:	Group Number:
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**PHYSICIAN/CLINIC INFORMATION**

Prescriber Name:	Physician UPIN#:	Physician NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:			
City, State, Zip:	Phone #:	Secure Fax #:		

**PREAUTHORIZATION INFORMATION**

<b>MEDICATION REQUESTED:</b> <b>CELEBREX®</b>
1. Patient's diagnosis to be treated with requested medication _____
2. Other diagnoses and/or prior history pertinent to this request _____
3. If the patient is at risk for a GI adverse event, please provide the reason _____ _____
4. Please list all medications the patient has previously tried and failed for treatment of this diagnosis _____ _____
5. Current over-the-counter and prescription medications _____ _____
6. Is the patient currently taking systemic corticosteroids on a regular basis ..... <input type="checkbox"/> YES <input type="checkbox"/> NO (e.g. long-term daily or pulse therapy)?
7. Is the patient currently taking an anticoagulant (e.g. warfarin)? ..... <input type="checkbox"/> YES <input type="checkbox"/> NO
8. Will the patient be taking aspirin daily? ..... <input type="checkbox"/> YES <input type="checkbox"/> NO

**Please fax or mail this form to:**  
Blue Cross and Blue Shield of Nebraska  
Pharmacy Department - UM  
7261 Mercy Road  
Omaha, NE 68180-0001  
**Toll Free Fax:** 877-232-6726  
**Phone:** 877-999-2374

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