BlueCross BlueShield
Federal Employee Program

# CELEBREX
# PRIOR APPROVAL REQUEST

**Send completed form to:**
**Service Benefit Plan**
**Prior Approval**
**P.O. Box 52080 MC 139**
**Phoenix, AZ 85072-2080**
**Attn. Clinical Services**
**Fax: 1-877-378-4727**

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

| **Patient Information (required)** | | | **Provider Information (required)** | | |
|---|---|---|---|---|---|
| Date: | | | Provider Name: | | |
| Patient Name: | | | Specialty: | NPI: | |
| Date of Birth: | Sex: ❑Male ❑Female | | Office Phone: | Office Fax: | |
| Street Address: | | | Office Street Address: | | |
| City: | State: | Zip: | City: | State: | Zip: |
| Patient ID: **R** | | | Physician Signature: | | |
| **PHYSICIAN COMPLETES** | | | | | |

## Celebrex (celecoxib)

***Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

**NOTE**: Form must be completed in its **entirety** for processing

Is this request for brand or generic? ❑Brand ❑Generic

Will the patient need more than 400 milligrams per day? ❑Yes***** ❑No

***If YES***, please specify the requested milligrams per day: _____ mg per day

1. What is the patient's diagnosis?
   - ❑ Acute pain
   - ❑ Ankylosing spondylitis
   - ❑ Chronic synovitis
   - ❑ Joint pain associated with hemophilia
   - ❑ Juvenile rheumatoid arthritis (JRA)
   - ❑ Osteoarthritis (OA) [aka degenerative joint disease (DJD)]
   - ❑ Primary dysmenorrhea
   - ❑ Rheumatoid arthritis (RA)
   - ❑ Other diagnosis ***(please specify)***: _____