



**Independence  
Blue Cross**

**Prior Authorization Form**

**Celebrex® (celecoxib), Mobic® (meloxicam), Ultram ER® (tramadol ER)**

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

Drug Requested: *(check one)*     Celebrex®     Mobic®     Ultram ER®

Date: \_\_\_\_\_ Patient ID#: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Prescribing Physician: \_\_\_\_\_ Office Contact: \_\_\_\_\_

Office Fax #: \_\_\_\_\_ Office Phone: \_\_\_\_\_

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

**1. DIAGNOSIS FOR DRUG REQUESTED:**

- Osteoarthritis     Rheumatoid arthritis     Familial Adenomatous Polyposis (FAP)
- Other (specify) \_\_\_\_\_

**2. MEDICATION HISTORY** (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

N/A If none or not applicable to diagnosis, indicate "N/A."

Drug Name	Date	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**3. PATIENT HISTORY:** (Celebrex and Mobic only)

- a. Does the patient have sulfonamide allergy?     Yes     No  
 (Sulfa allergy is exclusionary for Celebrex and that documentation of tolerating a trial of these agents would be required for approval).
- b. Does the patient have NSAIDs or aspirin allergy (i.e. ibuprofen, naproxen)?     Yes     No
- c. Is the patient currently on an anticoagulant (i.e. warfarin) within the last 90 days?     Yes     No
- d. Does the patient have any bleeding disorder?     Yes     No
- e. Is the patient currently on any concurrent systemic steroid treatment?     Yes     No
- f. Does the patient have a history of gastrointestinal bleed, peptic ulcer, GERD, or Barretts esophagus?     Yes     No

Please add any other supporting medical information that may be useful in the decision-making process:  
\_\_\_\_\_  
\_\_\_\_\_

**FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.**

<b>Internal use only</b>	<b>Coverage effective date</b> / /
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