



**COX 2 INHIBITOR
PRIOR AUTHORIZATION REQUEST
PHYSICIAN FAX FORM**

Only the prescriber may complete this form

The following documentation is **REQUIRED** for prior authorization. Incomplete forms will be returned for additional information. For formulary information, please visit the Blue Cross and Blue Shield of Kansas Web site at **www.bcbsks.com**

Today's Date: _____

PATIENT INFORMATION

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip	Patient Telephone:	

INSURANCE INFORMATION

BCBS ID Number:	Group Number:
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PHYSICIAN/CLINIC INFORMATION

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

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Medication Requested
<p>1. Patient's diagnosis to be treated with requested medication _____</p> <p>2. Other diagnoses and/or prior history pertinent to this request _____</p> <p>3. If the patient is at risk for a GI adverse event, please provide the reason _____</p> <p>4. Please list all medications the patient has previously tried and failed for treatment of this diagnosis. _____</p> <p>5. Current over-the-counter and prescription medications. _____</p> <p>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)?</p> <p>7. Is the patient currently taking an anticoagulant (e.g. warfarin)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

Please fax or mail this form to:

Prime Therapeutics LLC
Clinical Review Department
1020 Discovery Road, No. 100
Eagan, Minnesota 55121

TOLL FREE

Fax: 877.480.8130 **Phone:** 866.469.5660

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