Date _____

RESTAT
PRESCRIPTION BENEFIT MANAGERS

Client _____

PRIOR AUTH QUESTONNAIRE- CELEBREX®

M.D. Last Name: _____ ***M.D. First Name:*** _____

Physician Phone: _____ ***Physician Fax:*** _____

Patient _____ ***ID#*** _____ ***DOB*** _____

TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.

1. Please indicate patient's diagnosis:

☐ Acute pain ☐ Ankylosing Spondylitis ☐ Juvenile Rheumatoid Arthritis JRA (SKIP to #3)

☐ Osteoarthritis ☐ Rheumatoid Arthritis ☐ Familial adenomatous polyposis FAP (SKIP to #3)

☐ Primary dysmenorrhea ☐ Other diagnosis _____

2. List dates, and **please attach chart notes** to document member's failure on any prescription strength NSAID in the past 180 days:

Drug Used/Failed and Dates: _____

Nature of Failure: _____

3. Strength requested: ☐ 50mg ☐ 100mg ☐ 200mg ☐ 400mg
4. Dosage frequency requested: ☐ Once Daily Dosing ☐ Twice Daily Dosing
5. For JRA Patients ONLY, please list the patient's weight in kilograms: _____ KG
6. Please check if patient has any of the following: ☐ History of a GI bleed
   ☐ History of bleeding ulcers
   ☐ History of a serious bleeding disorder

7.	Is the patient currently treated with warfarin or other anticoagulants (other than aspirin)?	Yes	No
8.	Is the patient currently treated with systemic corticosteroids?	Yes	No
9.	Has the patient recently been or currently being treated with an antineoplastic drug?	Yes	No
10.	Is the patient taking a PPI due to concurrent NSAID usage?	Yes	No
11.	Would the patient discontinue the PPI if Celebrex is approved?	Yes	No
12.	Does the patient have a history of cardiovascular disease?	Yes	No

13. List the patient's known drug allergies _____

Physician Signature or name of person providing answers _____

Physician Comments _____

_____

_____

Send or Fax completed form to:
877-329-7279

RESTAT
P.O. BOX 758
WEST BEND, WI 53095

www.restat.com

QUESTIONS PLEASE CALL:
877-526-9906