

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



**BlueCross BlueShield  
 of Illinois**

**ONLY the prescriber may complete and fax this form.**

**Incomplete forms will be returned for additional information.** The following documentation is required for preauthorization consideration. For formulary information and to download additional forms, please visit [www.bcbsil.com](http://www.bcbsil.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: |
|-----------------|---------------|

**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**

|  |
|--|
| Patient's Diagnosis:   |
| Medication Requested:  |
| 1. Is the patient currently treated with the requested medication? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If yes, when was treatment with the requested medication started? _____ |
| 2. Other diagnoses and/or prior history pertinent to this request _____<br>_____   |
| 3. If the patient is at risk for a GI adverse event, please provide the reason _____<br>_____  |
| 4. Current over-the-counter and prescription medications _____<br>_____  |
| 5. Is the patient currently taking systemic corticosteroids on a regular basis ..... <input type="checkbox"/> Yes <input type="checkbox"/> No<br>(e.g. long-term daily or pulse therapy)?                    |
| 6. Is the patient currently taking an anticoagulant (e.g. warfarin)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No  |

**Please fax or mail this form to:**  
 Blue Cross and Blue Shield of Illinois  
 c/o Prime Therapeutics LLC, Clinical Review Department  
 1020 Discovery Road, No. 100  
 Eagan, Minnesota 55121

**TOLL FREE**

**Fax: 877.480.8130**

**Phone: 800.285.9426**

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