

# Drug Coverage Review Request

## COX-2 INHIBITORS

35045



### SUPPLY ALL PRESCRIBER AND PATIENT INFORMATION

#### PRESCRIBER

MD First Name \_\_\_\_\_  
MD Last Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_  
Fax \_\_\_\_\_  
DEA number (optional) \_\_\_\_\_

#### PATIENT

Cardholder's ID# \_\_\_\_\_  
Patient Last Name \_\_\_\_\_  
Patient First Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
State \_\_\_\_\_  
Zip Code \_\_\_\_\_  
Phone \_\_\_\_\_

### SECTION A Complete the section corresponding to the prescribed drug

Please specify the Name and Strength  
of the prescribed medication \_\_\_\_\_

### SECTION B Please answer the following questions

- YES  NO Is this drug being prescribed for use in reducing the number of adenomatous colorectal polyps in prevention or treatment of FAP (familial adenomatous polyposis)?
- YES  NO IF YES to the previous question, is the prescribed dose greater than 800 mg per day?
- YES  NO Is this drug being prescribed for the treatment of juvenile rheumatoid arthritis in a patient at least 2 years of age or older?
- YES  NO Is this drug being prescribed for the prevention or treatment of cancer or Alzheimer's disease?
- YES  NO Has this patient ever been diagnosed as having any of the following conditions: peptic ulcer disease (PUD), NSAID-related ulcer, clinically significant gastrointestinal bleeding?
- YES  NO Is the patient receiving corticosteroids or anticoagulants?
- YES  NO Has the patient previously been unable to tolerate drug therapy with at least TWO different NSAIDs?

### SECTION C Physician Signature

\_\_\_\_\_  
PHYSICIAN SIGNATURE

\_\_\_\_\_  
DATE

**FAX COMPLETED FORM TO: 1 800 837-0959**

PLEASE DO NOT FAX WITH A COVER SHEET

Location: Nevada (15) Case Id: 9999999



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