



**Independence  
Blue Cross**

**Prior Authorization Form**

**Celebrex, Mobic, Ultram ER, Flector patch, Voltaren gel, Ryzolt, Zipsor**

**ONLY COMPLETED REQUESTS WILL BE REVIEWED**

Drug Requested: *(check one)*

- Voltaren gel®   
  Celebrex®   
  Mobic®   
  Ultram ER®   
  Flector patch®   
  Ryzolt®  
 Zipsor®

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     N/A  
 (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     N/A
- c.** Is the patient currently on an anticoagulant (i.e. warfarin) within the last 90 days?  Yes     No     N/A
- d.** Does the patient have any bleeding disorder?  Yes     No     N/A
- e.** Is the patient currently on any concurrent systemic steroid treatment?  Yes     No     N/A
- f.** Does the patient have a history of gastrointestinal bleed, peptic ulcer, GERD, or Barrett's esophagus?  Yes     No     N/A

Please add any other supporting medical information that may be useful in the decision-making process including contraindications to medications related to the diagnosis:

\_\_\_\_\_  
\_\_\_\_\_

**FAX: (888) 671-5285 or EMAIL: [FSS\\_Standard\\_Medicare@catalystrx.com](mailto:FSS_Standard_Medicare@catalystrx.com)  
YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL**