

**COX-2 INHIBITORS  
PRIOR AUTHORIZATION  
PHYSICIAN FAX FORM**



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

**Incomplete forms will be returned for additional information.**

The following documentation is required for consideration of a prescription medication prior authorization.  
For formulary information, please visit the Blue Cross and Blue Shield of Kansas Web site: [www.bcbsks.com](http://www.bcbsks.com).

Patient name \_\_\_\_\_

BCBSKS ID number \_\_\_\_\_ Patient date of birth \_\_\_\_\_

Prescriber name \_\_\_\_\_ Clinic name & city \_\_\_\_\_

Clinic phone number \_\_\_\_\_ Clinic fax number \_\_\_\_\_

**DRUG REQUESTED** (Circle one)                      **BEXTRA**                      **CELEBREX**                      **VIOXX**

Patient diagnosis to be treated with the drug requested \_\_\_\_\_

Other diagnoses and/or prior history pertinent to this request \_\_\_\_\_

If the patient is at risk for a GI adverse event, please provide reason \_\_\_\_\_

Current over-the-counter and prescription medications \_\_\_\_\_

**PLEASE FAX OR MAIL THIS FORM TO:**

Prime Therapeutics, Inc.  
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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