



Prior Authorization Request (Physician to Complete)

Visit www.wellmark.com for the Wellmark Drug List for current medication tier levels and updated PA Forms

Facsimile Transmittal Sheet

Date: ____/____/____

To: Wellmark Pharmacy Services

From (Prescriber's Name): _____

Fax Number: (866) 884-4345

Prescriber's DEA Number: _____

Phone Number: (800) 600-8065

Prescriber's Phone Number: _____

Prescriber's Specialty: _____

Prescriber's Fax Number: _____

Prescriber's Office Address: _____
Street Suite # City State Zip

Patient Name: _____

Patient ID: _____ Patient DOB: ____/____/____

Please answer the following questions and fax this form back to (866) 884-4345. All fields are REQUIRED.

What is the primary cause of the patient's pain? _____

ICD-9 Code: _____

2. Specify Celebrex strength: 50mg 100mg 200mg 400mg

Quantity/30 days: _____ units Directions: _____

3. Is this an initial request or for continuation of therapy? _____

4. Is the patient currently using Celebrex samples? (Not a medication dispensed from the pharmacy)? _____

3. Is the patient receiving concurrent chronic (>3 months) systemic corticosteroid therapy? Yes No

If "Yes", please specify corticosteroid(s) patient is receiving: _____

4. Is the patient currently taking an anti-coagulant (excluding aspirin)? Yes No

If "Yes", please specify anti-coagulant(s) patient is receiving: _____

5. Has the patient received traditional NSAID/PPI therapy in the last 12 months? Yes No

If "Yes", please specify NSAID(s)/PPI(s) received and reason(s) for discontinuation: _____

If "No", what medical condition(s) would prevent the patient from trying said therapy? _____

Printed Name

Signature

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