BRANCH MEDICAL CLINIC PHARMACY NSA MID-SOUTH
COX-2 PRIOR AUTHORIZATION FORM

To Provider: To ensure appropriate use of COX-2 inhibitors, this form must be completed prior to Branch Medical Clinic Pharmacy, Millington dispensing medication.

Patient Name:_____ Last 4 of Sponsor's SSN:_____

Medication (check one): _____ Bextra (Valdecoxib)

_____ Celebrex (Celecoxib)

_____ Vioxx (Rofecoxib)

A check mark by one of the below will meet the criteria for COX-2 therapy.

_____ History of peptic ulcer disease

_____ History of NSAID- related gastritis

_____ Concomitant use of corticosteroids or anticoagulants

_____ Patient failed NSAID therapy with at least two (2) BMC Pharmacy, Millington Formulary NSAIDs

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FAXES OR MAILED IN FORMS WILL NOT BE ACCEPTED.

VALID PROVIDER SIGNATURE : _____
REQUIRED The above provider signature is verification that the selected criteria are accurate for this patient.

PROVIDER PHONE #: _____

**** THIS FORM MUST BE PRESENTED TO THE PHARMACY ALONG ****
WITH AN ATTACHED COMPLETED PRESCRIPTION.