



# PRIOR AUTHORIZATION PROGRAM FORM

Anti-inflammatory Agent – Celebrex® (Celecoxib,)

**Instructions:**

1. Section 1 to be completed by Plan Member/ Patient
2. Section 2 to be completed by Physician/ Pharmacist (expenses incurred by the completion of this form is at plan member's expense)
3. Section 3 to be completed by Pharmacist.
4. Please fax completed form to Formulary Management at 647-722-3054 (Toronto Area) / (Toll Free Fax) 1-866-262-0007 or mail to 145 The West Mall P.O. Box 110 U, Toronto, Ontario, M8Z 5M4.

**Section 1:  
Patient Information**

Cardholder's Name: (Last , First )	Certificate Number:		
Patient's Name: (Last, First)	Patient's Date of Birth (dd/mm/yy)	Relationship to Cardholder: Employee      Spouse      Dependent	
Contact Information: Pharmacy Name:	Number (    )	OR	
Patient / Legal Guardian Name:	Number (    )		

Signature of Patient/ Legal Guardian: \_\_\_\_\_ Date (dd/mm/yy): \_\_\_\_\_

**Section 2:  
Prescribed Drug Information**

Drug Name:	Drug Strength:	Dosage Instructions:
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**Eligibility for drug coverage is determined if the patient meets at least one of the qualifying criteria listed below. In the case where the patient has another drug plan; prior authorization may cover a portion that is not paid by the primary plan.**  
Please indicate if the patient meets at least one of the qualifying criteria for drug coverage:

- For acute and chronic use in the relief of the signs and symptoms of osteoarthritis and rheumatoid arthritis in adults
- Patient is taking concurrent warfarin therapy
- Patient is taking concurrent prednisone therapy
- Patient has a history of treated ulcers
- Patient has failed to respond or is intolerant to a minimum of 2 prescription – requiring NSAID medications e.g. Diclofenac, Naproxen, Meloxicam.

Physician's Name: (Last, First)	License Number:
Address: (Street, City, Province, Postal Code)	Telephone Number : (    ) - Fax Number:            (    ) -

Signature of Physician: \_\_\_\_\_ Date (dd/mm/yy): \_\_\_\_\_

**Section 3:  
Pharmacist Information**

Pharmacy Name:	Provider Number:
Pharmacy Address: (Street, City, Province, Postal Code)	Telephone Number : (    ) - Fax Number:            (    ) -

Signature of Pharmacist: \_\_\_\_\_ Date (dd/mm/yy): \_\_\_\_\_

Pharmacist Name: (Print Last, First) \_\_\_\_\_

**Internal Office Use Only:**

Date Received:	DIN Number:	HICL:	Date Approved:
Effective Date:	Termination Date:	Approved: YES or NO	Approved by:
Notified: Pharmacy Member	Notification Date		