



CELECOXIB SPECIAL AUTHORIZATION REQUEST FORM

Patients may or may not meet eligibility requirements as established by
Alberta Government sponsored drug programs.

Please complete all required sections to allow your request to be processed.

PATIENT INFORMATION				COVERAGE TYPE:	
PATIENT LAST NAME	FIRST NAME	INITIAL	<input type="checkbox"/> Alberta Blue Cross <input type="checkbox"/> Alberta Human Services <input type="checkbox"/> Other		
DATE OF BIRTH: Year / Month / Day		ALBERTA PERSONAL HEALTH NUMBER			
STREET ADDRESS		CITY	PROV	POSTAL CODE	IDENTIFICATION/CLIENT/COVERAGE No:

PRESCRIBER INFORMATION					
PREScriBER LAST NAME	FIRST NAME	INITIAL	PRESCRIBER PROFESSIONAL ASSOCIATION REGISTRATION <input type="checkbox"/> CPSA <input type="checkbox"/> ACO REGISTRATION NO. <input type="checkbox"/> CARNA <input type="checkbox"/> ADA+C <input type="checkbox"/> ACP <input type="checkbox"/> Other		
STREET ADDRESS			PHONE:		
CITY, PROVINCE			FAX:		
POSTAL CODE			FAX NUMBER MUST BE PROVIDED WITH EACH REQUEST SUBMITTED		

Criteria for Coverage of CELECOXIB

For patients who are at high risk of upper gastrointestinal (GI) complications due to a proven history of prior complicated GI events (e.g. GI perforation, obstruction or major bleeding), OR

For patients who have a documented history of ulcers proven radiographically and/or endoscopically.

Special authorization may be granted for 6 months.

This product is eligible for auto-renewal.

NEW Please provide the following information for NEW requests (check ALL that apply):

1) Is this patient at high risk of upper GI complications? Yes No

2) Does this patient have a documented history of ulcers? Yes No

Additional information relating to request:

RENEWAL
 This product is eligible for auto-renewal. A Special Authorization renewal request is required only if the Special Authorization approval has lapsed (i.e. the patient has not made a claim for the drug product during the Approval Period).

Please indicate response to therapy:

PREScriBER'S SIGNATURE	DATE	Please forward this request to: • Alberta Blue Cross, Clinical Drug Services 10009-108 Street NW, Edmonton, Alberta T5J 3C5 FOR CELECOXIB REQUESTS ONLY: • FAX: 780-401-1150 in Edmonton • 1-888-401-1150 toll free all other areas
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ONCE YOUR REQUEST HAS SUCCESSFULLY TRANSMITTED, PLEASE DO NOT MAIL OR RE-FAX YOUR REQUEST.

THIS SECTION IS FOR ALBERTA BLUE CROSS USE ONLY

The information on this form is being collected and pursuant to sections 20, 21 and 22 of the Health Information Act, and sections 33 and 34 of the Freedom of Information and Protection of Privacy Act, for the purposes of determining or verifying eligibility to participate in a program or receive a benefit, product or health service. If you have any questions regarding the collection or use of this information, please contact an Alberta Blue Cross privacy matters representative toll-free at 1-855-498-7302 or write to Privacy Matters, Alberta Blue Cross, 10009 - 108 Street, Edmonton AB T5J 3C5.

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