



Prior Authorization Criteria for Cox II Inhibitors

Please list medication: _____

Cox II Inhibitors reduce the rate of clinically important NSAID ulcers by 60%. It does not completely eliminate them. Its pain relief is equivalent to the older NSAIDs.

****Medications will be reviewed based on FDA approved indications****

Patient Name: _____ DOB: _____

Doctor: _____ Diagnosis: _____

Please circle response:

1. Is the patient 18 years old or older? If yes, continue to **2**. If no, send to WHP.

2. Does the patient have the diagnosis of **Osteoarthritis**? If yes, go to **A**. If no, go to **3**.
 - A**. Is the use of acetaminophen contraindicated (e.g., intolerant or on Coumadin)? If yes, go to **3C**. If no, go to **B**.
 - B**. Has the patient had a two-week trial of 3-4 grams daily of acetaminophen and failed to respond adequately? If yes, continue to **3C**. If no, send to WHP.

3. Does the patient have the diagnosis **Rheumatoid arthritis, Dysmenorrhea or Acute Pain**?
If yes go to **C**. If no, send to WHP.
 - C**. Does the patient have a history of an NSAID-associated GI adverse event (e.g., nausea, vomiting, diarrhea/constipation, abdominal pain, or dyspepsia) after a minimum of 2 weeks of NSAID therapy that has occurred with at least two different NSAIDs? If no, go to **D**. If yes, list NSAIDs tried _____, _____ then send to WHP.
 - D**. Is the patient at risk for NSAID-induced GI adverse events? (Risk factors may include, but are not limited to, the following: age 60 or older; history of peptic ulcer or GI bleed; concomitant use of corticosteroids or anticoagulants; ARA functional class III or IV). Please circle the risk factors of your patient then send to WHP.

Check box if this authorization is for a renewal of therapy, then send to WHP.

Sent in by: _____ Phone: _____ Fax: _____

Fax information to our Pre-Certification Dept. at 716-541-6344. For questions call: 812-426-6600