

Remove above portion before faxing. Please complete the form in its entirety and fax with requested clinicals to the number above.

VYS26-01

PATIENT INFORMATION				
First Name	Last Name	Date of Birth ____ / ____ / ____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Address		City	State	Zip
email		Home Phone	Cell Phone	

PRESCRIBER INFORMATION				
Prescriber Full Name		Prescriber Credential		
Office Address		City	State	Zip
Office email	Office Phone	Office Fax	Cell Phone	
Practice Contact Person		Prescriber NPI	Preferred Contact Method <input type="checkbox"/> email <input type="checkbox"/> Phone <input type="checkbox"/> Fax	

CLINICAL INFORMATION – please include any relevant office visit/lab notes to support this prescription	
Patient is <input type="checkbox"/> Naïve <input type="checkbox"/> Previously Treated	Patient weight: ____ kg
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Drug Allergies (please list)	
Previous Therapies Tried (please check name and include dates)	
<input type="checkbox"/> Acetaminophen	Date ____ / ____ / ____
<input type="checkbox"/> Topical NSAIDs Please list name(s): _____	Date ____ / ____ / ____
<input type="checkbox"/> Oral NSAIDs Please list name(s): _____	Date ____ / ____ / ____
<input type="checkbox"/> Physical and Occupational Therapy	Date ____ / ____ / ____
<input type="checkbox"/> Other _____	Date ____ / ____ / ____
Current Medications (please list name and dose):	Reason(s) for Therapeutic Failure/Therapy Not Tried:
	<input type="checkbox"/> Pill Dysphagia
	<input type="checkbox"/> Previous adverse reaction(s)
	<input type="checkbox"/> Drug interaction(s)
	<input type="checkbox"/> Other (please list):
ICD-10 Code <input type="checkbox"/> M19.90 Osteoarthritis (unspecified)	<input type="checkbox"/> M08.20 Juvenile Rheumatoid Arthritis (unspecified)
<input type="checkbox"/> M06.9 Rheumatoid Arthritis (unspecified)	<input type="checkbox"/> Other: _____
<input type="checkbox"/> M45.9 Ankylosing Spondylitis (unspecified)	

PRESCRIPTION – please check all boxes across row				
Medication	Strength	Directions	Quantity	Refills
<input type="checkbox"/> Vyscoxa® (celecoxib oral solution)	10 mg/mL	<i>Osteoarthritis</i> <input type="checkbox"/> Administer 200 mg by mouth once daily <input type="checkbox"/> Administer 100 mg by mouth twice daily <i>Rheumatoid Arthritis</i> <input type="checkbox"/> Administer 100 mg by mouth twice daily <input type="checkbox"/> Administer 200 mg by mouth twice daily <i>Ankylosing Spondylitis</i> <input type="checkbox"/> Administer 200 mg by mouth daily <input type="checkbox"/> Administer 100 mg by mouth twice daily <input type="checkbox"/> Administer 200 mg by mouth twice daily <i>Juvenile Rheumatoid Arthritis (2 years and older)</i> <input type="checkbox"/> Administer 50 mg by mouth twice daily (weight between 10 kg and 25 kg) <input type="checkbox"/> Administer 100 mg by mouth twice daily (weight >25 kg)	<input type="checkbox"/> 1 bottle = 473 mL <input type="checkbox"/> 2 bottles = 946 mL <input type="checkbox"/> 3 bottles = 1,419 mL <input type="checkbox"/> _____	<input type="checkbox"/> 11 <input type="checkbox"/> _____

By signing below, I authorize the pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process. I also certify that the above therapy is medically necessary and that the information above is accurate to the best of my knowledge.

Prescriber's signature: _____ MD DO PA CRNP Date: ____ / ____ / ____

NO STAMPS

In order for a brand name product to be dispensed, the prescriber must handwrite "Brand Necessary" or "Brand Medically Necessary" on the prescription.

Note: The information contained in this document will become a legal prescription. Prescriber is to comply with all state-specific Pharmacy and Medical Board guidelines such as e-prescribing, state specific prescription form, fax language, number of prescriptions allowed on a single prescription form, etc. If more than one page is required, make additional copies. Non-compliance with state-specific requirements could result in outreach to the prescriber.