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**CONTAINS CONFIDENTIAL PATIENT INFORMATION**

# meloxicam

**Prior Authorization of Benefits (PAB) Form**
**Complete form in its entirety and fax to:**
**Prior Authorization of Benefits Center at 1-844-474-3341**

| 1. PATIENT INFORMATION | 2. PHYSICIAN INFORMATION |
|---|---|
| | Prescribing Physician: ______________ |
| Patient Name: ______________ | Physician Address: ______________ |
| Patient ID #: ______________ | Physician Phone #: ______________ |
| Patient DOB: ______________ | Physician Fax #: ______________ |
| Date of Rx: ______________ | Physician Specialty: ______________ |
| Patient Phone #: ______________ | Physician DEA: ______________ |
| Patient Email Address: ______________ | Physician NPI #: ______________ |
| | Physician Email Address: ______________ |

| 3. MEDICATION | 4. STRENGTH | 5. DIRECTIONS | 6. QUANTITY PER 30 DAYS |
|---|---|---|---|
| meloxicam | □ 7.5mg tablet □ 15mg tablet<br>□ 7.5mg/mL susp | ______________ | Specify: ______________ |

**7. DIAGNOSIS:** ______________

**8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY**

**NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.**

Patient age: ______________

☐ Yes ☐ No Patient has a diagnosis of PUD or GI bleed in the last 730 days

☐ Yes ☐ No Patient has a history of warfarin therapy for 30 days in the last 45 days

☐ Yes ☐ No Patient has a history of corticosteroid therapy for greater than or equal to 35 days in the last 90 days

☐ Yes ☐ No Patient has taken high dose NSAID therapy for 30 days in the last 45 days

☐ Yes ☐ No Patient has a diagnosis of RA, JRA, or OA in the last 730 days

☐ Yes ☐ No Patient has a history of a DMARD agent for 30 days in the last 60 days

☐ Yes ☐ No Patient has a history of 2 or more NSAID agents for 30 days in the last 180 days

☐ Yes ☐ No Patient has a diagnosis of FAP or ankylosing spondylitis in the last 730 days

**9. PHYSICIAN SIGNATURE**

______________ ______________
Prescriber or Authorized Signature Date

*Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.*

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

The document(s) accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation.
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Providers: You are required to return, destroy or further protect any PHI received on this document pertaining to members whom you are not currently treating. Providers are required to immediately destroy any such PHI or safeguard the PHI for as long as it is retained. In no event are you permitted to use or re-disclose such PHI.

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