

## PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross<sup>®</sup> BlueShield<sup>®</sup> of South Carolina

Patient Information	
Name:	Insurance ID #:
Address:	Birthdate:

Provider Information	
Physician Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

### When this form is completed, please fax to Caremark at 888-836-0730.

This fax machine is located in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures.

- Has the patient been using the requested brand-name drug during the past year?  
[If the answer to this question is yes, no further questions are required.]  Y  N
- Has the patient had a trial of generic zolpidem or zaleplon?  
[If the answer to this question is no, no further questions are required.]  Y  N
- Did the patient have an inadequate response after at least a 15 day trial of generic zolpidem or zaleplon in the last 365 days?  
[If the answer to question is yes, skip to question 5.]  Y  N
- Is the patient intolerant to, or has the patient had an adverse reaction with generic zolpidem or zaleplon?  
[If the answer to this question is no, no further questions are required.]  Y  N
- Is Lunesta the drug being requested?  
[If the answer to this question is yes, no further questions are required.]  Y  N
- Has the patient had a trial of Lunesta?  
[If the answer to this question is no, no further questions are required.]  Y  N

# LUNESTA

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7. Did the patient have an inadequate response after at least a 15 day trial of Lunesta in the last 365?  
[If the answer to this question is yes, no further questions are required.]  Y  N
8. Is the patient intolerant to, or has the patient had an adverse reaction to Lunesta?  Y  N

If the patient will require more than 45 tablets/capsules in a 90 day period, an additional authorization will be required.  
Please call 800-294-5979 for assistance with this issue.

**Comments:** \_\_\_\_\_

*Information on this form is accurate as of the date below.*

<b>Prescriber's Signature:</b>	<b>Date:</b>
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