

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross[®] BlueShield[®] of South Carolina

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

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

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

This fax machine is 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.

- Does the patient have the diagnosis of moderate-to-severe pain? Y N
- Is the patient being prescribed extended release morphine for around-the-clock pain relief? Y N
- Has the patient been assessed for clinical risks of opioid abuse and/or addiction by one of the following tools or another assessment tool for opioid abuse: CAGE questionnaire, Cyr-Wartman Screen, Skinner Trauma Screen, Screener and Opioid Assessment for Patients with Pain (SOAPP)? Y N
- Is the drug being requested MS Contin, Oramorph SR or Extended Release Morphine?
[If the answer to this question is no, skip to question 6.] Y N
- Is the drug being dosed more often than every eight hours?
[No further questions are required.] Y N
- Is the request for Kadian?
[If the answer to this question is no, then skip to question 8.] Y N

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7. Is the drug being dosed more often than every 12 hours?
[No further questions are required.] Y N
8. Is the request for Avinza?
[If the answer to this question is no, then no further questions are required.] Y N
9. Is the drug being dosed more often than every 24 hours? Y N
10. Does the total daily dose of Avinza exceed 1600 mg? Y N

Comments: _____

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

Prescriber's Signature:	Date:
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