OPANA

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.

1. Does the patient have a diagnosis of moderate or severe hepatic impairment? Y N
2. Does the patient have a diagnosis of respiratory depression? Y N
3. Does the patient have a diagnosis of acute asthma, severe bronchial asthma or hypercarbia? Y N
4. Does the patient have a diagnosis of, or is suspected of having paralytic ileus? Y N
5. Does the patient have a diagnosis of moderate-to-severe pain? Y N
6. Is the patient currently on daily opioid therapy? Y N

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	Question		
7.	Is the patient being prescribed Opana ER for around-the-clock pain relief for an extended period of time?	Y	N
8.	Is the patient taking Opana ER more often than every 12 hours?	Y	N
9.	Did the patient have a dosage adjustment since the previous prescription was filled?	Y	N
10.	Does the patient require more than 160 mg in a 24-hour period? [If the answer to this question is no, then no further questions are required.]	Y	N
11.	Is the patient opioid tolerant?	Y	N

Comments: ____

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

Prescriber's Signature:	**Date:**

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