METHADONE TABLETS

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 800-294-5979 with any questions concerning prior authorization procedures.

1. Is the methadone being prescribed for detoxification of a narcotic addicted patient? [If the answer to this question is yes, no further questions are required.] Y N
2. Is the methadone being prescribed as part of a methadone maintenance program? [If the answer to this question is yes, no further questions are required.] Y N
3. Does the patient required more than 240 tablets (5 mg and 10 mg) or 60 tablets (40 mg) per month? [If the answer to this question is no, prior authorization is not required. These quantities are available without a prior authorization.] Y N
4. Does the patient have the diagnosis of moderate to severe pain? [If the answer to this question is no, no further questions are required.] Y N
5. Is the patient tolerant to the analgesic effects of narcotics? [If the answer to this question is no, no further questions are required.] Y N
6. Does the patient have chronic or cancer pain requiring continual narcotic analgesia? Y N
7. Will the patient be monitored for respiratory depression during initiation of methadone and/or conversion of pain patients to methadone treatment from treatment with other opiod agonists and during dose titration? Y N

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