

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross BlueShield of South Carolina

| Patient Information | |
|---------------------|------------------------|
| Name: | Insurance ID #: |
| Group #: | 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 1-888-836-0730.

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.

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| 1. Does the medication meet the Medicare definition of a drug or biological (e.g., the drug appears in the latest edition of the USP-NF or American Dental Association guide to dental therapeutics)? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 2. Is this an injectable formulation of the drug? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 3. Is the patient enrolled in Medicare Part B? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 4. Has this drug claim been submitted through Medicare Part B? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 5. Was the drug claim denied by Medicare Part B? | <input type="checkbox"/> Y | <input type="checkbox"/> N |

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6. Is the drug excluded from Medicare benefit coverage (e.g., immunizations, antigens)?

 Y N

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| 7. Is the drug delivered through intravenous administration? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 8. Is the drug administered through an implantable pump? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 9. Is the drug administered through an external pump? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 10. Is the drug included under a local coverage policy for the applicable Medicare DMERC? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 11. Is the drug generally self-injected by a patient more than 50% of the time in an outpatient setting? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 12. Is the physician purchasing and providing the drug "incident to" physician services? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 13. Does the patient have the diagnosis of chronic hepatitis C? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 14. D Does the patient have a history of unstable heart disease (e.g., coronary artery disease (CAD), ischemic heart disease, congestive heart failure)? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 15. Does the patient have a creatinine clearance ≥ 50 mL/min/1.73 m ² ? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 16. Will the physician monitor the patient's hemoglobin during Rebetron treatment? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 17. Is the physician aware that labeling recommends that all patients treated with an interferon be monitored for evidence of depression? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 18. Is the patient male? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 19. Does the patient have a partner who is pregnant? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 20. Is the patient a female of child bearing potential? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 21. Is the patient pregnant? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 22. Has or will the patient be instructed to practice effective contraception during therapy and for 6 months after therapy? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 23. Has the patient been receiving interferon treatment within the previous 3 months? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 24. Is the patient Genotype-I? | <input type="checkbox"/> Y | <input type="checkbox"/> N |

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| 25. Did the patient experience at least a 2-log decrease in viral load during treatment? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 26. Did the patient have detectable levels of hepatitis C virus (HCV) RNA (a viral load) in the serum at the end of the initial treatment period? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 27. Did the patient have a normalization of serum alanine aminotransferase (ALT) during the initial treatment period? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 28. Does the patient have detectable levels of hepatitis C virus (HCV) RNA (a viral load) in the serum? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 29. Does the patient have persistently elevated serum alanine aminotransferase (ALT) levels? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 30. Does the patient have signs of chronic hepatitis on liver biopsy? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 31. Is the patient Genotype-1? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 32. Does the patient have a hemoglobin level greater than 8.5 g/dL? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 33. Was the patient previously treated with an interferon product as monotherapy for hepatitis C and has now relapsed? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 34. Has the patient received a total of 12 months of therapy with a combination of an interferon product and oral ribavirin? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 35. Has the patient received a total of 6 months of therapy with a combination of an interferon product and oral ribavirin? | <input type="checkbox"/> Y | <input type="checkbox"/> N |

Comments: _____

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

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| Prescriber's Signature: | Date: |
|--------------------------------|--------------|