

## PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross BlueShield of South Carolina

Patient Information	
<b>Name:</b>	<b>Insurance ID #:</b>
<b>Group #:</b>	<b>Birthdate:</b>

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

**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.

- |   |                            |                            |
|---|----------------------------|----------------------------|
| 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 |
| 6. Is the drug excluded from Medicare benefit coverage (e.g., immunizations, antigens)?   | <input type="checkbox"/> Y | <input type="checkbox"/> 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 |
|  |                            |                            |
| 1. Is the patient female?  | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 2. Is the patient being treated for inoperable metastatic breast cancer?                                 | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 3. Is the patient 1 to 5 years postmenopausal or had an oophorectomy (surgically menopausal)?            | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 4. Has the patient had an incomplete response to other therapy for metastatic breast cancer?             | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 5. Is the patient being treated for primary hypogonadism (congenital or acquired)?                       | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 6. Is the patient being treated for hypogonadotropic hypogonadism (congenital or acquired)?              | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 7. Is the patient being treated for delayed puberty?   | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 8. Will the patient have bone development checked at least every 6 months?                               | <input type="checkbox"/> Y | <input type="checkbox"/> N |

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

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

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