

DEPO-TESTOSTERONE



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.

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)? Y N
2. Is this an injectable formulation of the drug? Y N
3. Is the patient enrolled in Medicare Part B? Y N
4. Has this drug claim been submitted through Medicare Part B? Y N
5. Was the drug claim denied by Medicare Part B? Y N
6. Is the drug excluded from Medicare benefit coverage (e.g., immunizations, antigens)? Y N
7. Is the drug delivered through intravenous administration? Y N

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8. Is the drug administered through an implantable pump? Y N
9. Is the drug administered through an external pump? Y N
10. Is the drug included under a local coverage policy for the applicable Medicare DMERC? Y N
11. Is the drug generally self-injected by a patient more than 50% of the time in an outpatient setting? Y N
12. Is the physician purchasing and providing the drug "incident to" physician services? Y N
13. Is the patient male? Y N
14. Does the patient have a diagnosis of primary hypogonadism (congenital or acquired)? Y N
15. Does the patient have a diagnosis of hypogonadotropic hypogonadism (congenital or acquired)? Y N

Comments: _____

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

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