PROTOPIC

MedBlue RX℠
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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. Is the patient 2 years of age or older? Y N
2. Does the patient have the diagnosis of moderate to severe atopic dermatitis (eczema)? Y N
3. Has the patient tried and had an inadequate response to at least two medium or higher potency topical corticosteroids? Y N
4. Does the patient have a contraindication or allergy to all corticosteroids (not the vehicle)? Y N
5. Is the prescription for Protopic 0.1% intment? Y N
6. Is the patient 16 years of age or older? Y N

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7. Does the patient have a weakened or compromised immune system? Y N

Comments: ____

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

Prescriber's Signature:	**Date:**

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