

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 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.

- Does the patient have a diagnosis of narcolepsy? Y N
- Has the diagnosis of narcolepsy been confirmed by polysomnography and Multiple Sleep Latency Test? Y N
- Does the patient have a diagnosis of Obstructive sleep apnea? Y N
- Has the diagnosis of obstructive sleep apnea been confirmed by polysomnography with respiratory monitoring? Y N
- Is the patient currently utilizing continuous positive airway pressure (CPAP) therapy? Y N
- Has the therapy with CPAP been maximized? Y N

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7. Does the patient experience excessive daytime sleepiness despite optimal CPAP therapy? Y N
8. Will the patient continue treatment with CPAP? Y N
9. Will the physician periodically assess compliance with CPAP therapy? Y N
10. Does the patient have a diagnosis of Shift Work Sleep Disorder (SWSD)? Y N
11. Does the patient work the night shift (at least 5 hours between the hours of 11 pm and 7 am) permanently? Y N
12. Does the patient work the night shift (at least 5 hours between the hours of 11pm and 7 am frequently (5 times or more per month) on a rotating basis? Y N
13. Does the patient experience excessive sleepiness while working? Y N
14. Does the sleep disturbance cause clinically significant distress or occupational impairment? Y N
15. Is the sleep disturbance a direct physiological effect of a drug or a general medical condition? Y N
16. Have other sleep disorders or mental disorders been ruled out? Y N

Comments: _____

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

Prescriber's Signature:	Date:
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