

RETIN-A MICRO

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.

1. Is the patient 12 years old or older? Y N
2. Does the patient have the diagnosis of acne vulgaris? Y N
3. Has the patient tried and failed at least 2 of the following categories: Glycolic acid products, sulfur products, resorcinol products, salicylic acid products, benzoyl peroxide products, decarboxylic acids, topical antibiotics, oral antibiotics? Y N

Comments: _____

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

Prescriber's Signature:	Date:
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