

TRETINOIN

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. Does the patient have the diagnosis of Keratosis Follicularis (Darier's disease, Darier-White disease)? Y N
[If the answer to this question is yes, then no further questions required.]
2. Does the patient have the diagnosis of Acne Vulgaris? Y N
3. Has the patient tried and failed products from the following categories:
 - Salicylic acid products (e.g., Clearasil, Stir-Dex), Y N
 - Benzoyl Peroxide products (e.g., Oxy-10, Benzac AC, Triaz)[If the answer to this question is yes, then no further question required.]
4. Has the physician considered using all of the therapies listed in question 3 but deemed all of them inappropriate for the patient? Y N

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PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM MedBlueRXSM and MedBlue RX PlusSM

Comments: _____

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

Prescriber's Signature:	Date:
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