

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.

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|---|----------------------------|----------------------------|
| 1. Is the patient greater than 18 years of age? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 2. Is the patient female? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 3. Does the patient have a diagnosis of irritable bowel syndrome (IBS)? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 4. Is the constipation the primary symptom of the patient? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 5. Is the patient less than 65 years of age? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 6. Does the patient have a diagnosis of chronic constipation (constipation for more than 6 months)? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 7. Is the constipation due to other diseases or drugs? | <input type="checkbox"/> Y | <input type="checkbox"/> N |

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8. Does the patient have a diagnosis of severe renal impairment? Y N
9. Does the patient have a diagnosis of moderate to severe hepatic impairment? Y N
10. Does the patient have a history of bowel obstruction? Y N
11. Does the patient have a diagnosis of symptomatic gallbladder disease? Y N
12. Does the patient have a suspected sphincter of Oddi dysfunction? Y N
13. Does the patient have a history of abdominal adhesions? Y N
14. Has the patient received at least 4 weeks of Zelnorm therapy? Y N
15. Has the patient responded well to therapy? Y N
16. Has the patient received a total of 12 weeks of therapy? Y N

Comments: _____

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

Prescriber's Signature: 	Date:
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