PANTOPRAZOLE

MEDICARE ADVANTAGE PRIOR AUTHORIZATION REQUEST FORM
BlueCross® BlueShield® of South Carolina

Patient Information	
Name:	**Insurance ID #:**
Address:	**Birthdate:**

Provider Information	
Physician's Name:	**Physician DEA #:**
Phone:	**Fax:**
Office Address:	
Diagnosis:	**ICD-9 Code:**

When this form is complete, please fax to Caremark at 888-836-0730.

This fax machine is 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 800-294-5979 with any questions concerning prior authorization procedures.

1. Does the participant have a diagnosis of H. pylori? [If the answer to this question is yes, no further questions are required.] Y N
2. Does the participant have a documented contraindication to or a potential drug interaction with generic omeprazole? [If the answer to this question is yes, no further questions are required.] Y N
3. Is the participant intolerant to or had a confirmed adverse event with generic omeprazole? [If the answer to question is yes, then no further questions are required.] Y N
4. Has the participant demonstrated an inadequate treatment response for at least a 15 day trial of generic omeprazole? [If the answer to this question is yes, no further questions are required.] Y N
5. Does the participant require use of a specific dosage form (e.g., suspension, solution) that is not available as generic omeprazole? Y N

Comments: ______________________________

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

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association.

Prescriber's Signature:	**Date:**

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