

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 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. Is the patient currently taking Saphris with evidence of improvement?
[If the answer to this question is yes, no further questions are required.] Y N
2. Has the patient tried and failed a 30-day trial of generic risperidone (any dosage form), Zyprexa, Geodon, Seroquel or Seroquel XR?
[If the answer to this question is yes, no further questions are required.] Y N
3. Is the patient intolerant to, or has the patient had an adverse reaction to generic risperidone (any dosage form), Xyprexa, Geodon, Seroquel or Seroquel XR? Y N

Comments: _____

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

Prescriber's Signature:	Date:
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