

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. Does the patient have a diagnosis of advanced renal cell carcinoma (RCC)?
[If the answer to this question is yes, skip to question 5.] Y N
2. Does the patient have a diagnosis of gastrointestinal stromal tumor (GIST)? Y N
3. Did the GIST of the patient progress during treatment with imatinib mesylate?
[If the answer to this question is yes, skip to question 5.] Y N
4. Was the patient intolerant of imatinib mesylate? Y N
5. Is the patient a female of childbearing potential?
[If the answer to this question is no, skip to question 7.] Y N

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6. Has pregnancy been excluded as confirmed by a negative urine or serum pregnancy test? Y N
7. Has the patient been instructed on appropriate contraceptive methods and the importance of not conceiving a child during Sutent therapy? Y N

Comments: _____

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

Prescriber's Signature:	Date:
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