UROXATRAL

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. Has the patient been using the requested brand-name drug during the past year? Y N
   [If the answer to this question is yes, no further questions are required.]
2. Has the patient had a trial of generic doxazosin or terazosin? Y N
   [If the answer to this question is no, no further questions are required.]
3. Did the patient have an inadequate response after at least a 15-day trial of generic doxazosin or terazosin in the last 365 days? Y N
   [If the answer to this question is yes, no further questions are required.]
4. Is the patient intolerant to, or has the patient had an adverse reaction with generic doxazasin or terazosin? Y N

Comments: _____

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

Prescriber's Signature:	Date:

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