

VENTAVIS (MEDICARE DETERMINATION)

PHYSICIAN 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. Is the patient a resident of a long-term care facility? Y N
2. Has the patient received a nebulizer machine covered through the Medicare benefit? Y N
3. Does the patient have a diagnosis of pulmonary arterial hypertension (PAH), (WHO Group 1)?
[If the answer to this question is no, no further questions are required.] Y N
4. Has PAH been confirmed by right heart catheterization?
[If the answer to this question is yes, skip to question 7.] Y N
5. Is the patient an infant with any of the following conditions?
 - Post cardiac surgery
 - Chronic lung disease associated with prematurity
 - Chronic heart disease
 - Congenital diaphragmatic hernias[If the answer to this question is no, no further questions are required.] Y N
6. Has Doppler echocardiogram been performed to diagnose PAH?
[If the answer to this question is no, no further questions are required.] Y N

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7. Does the patient experience New York Heart Association (NYHA) Class III or IV symptoms?

 Y N

Comments: _____

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

Prescriber's Signature:	Date:
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