

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 participant have a documented contraindication to or a potential drug interaction with a generic HMG (e.g., lovastatin, pravastatin, simvastatin), or is the participant status post acute coronary syndrome with very high LDL (e.g., greater than 190mg/dL) and unable to reach the goal with the available generic dose? Y N
[If the answer to this question is yes, no further questions are required.]
2. Is the participant intolerant to or had a confirmed adverse event with a generic HMG (e.g., lovastatin, pravastatin, simvastatin)? Y N
[If the answer to this question is yes, no further questions are required.]
3. Has the participant demonstrated an inadequate treatment response after at least a 30-day trial of a generic HMG (e.g., lovastatin, pravastatin, simvastatin)? Y N

Comments: _____

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

Prescriber's Signature:	Date:
-------------------------	-------