ANDRODERM

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)? Y N
[If the answer to this question is no, no further questions are required.]
2. Has the patient tried and failed previous treatment with either Sutent (sunitinub) or Nexavar (sorafenib)? Y N

Comments: ____

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

Prescriber's Signature:	**Date:**

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