

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.

- Does the patient have known or suspected mechanical gastrointestinal obstruction?
(Examples include obstruction due to adhesions, tumors, hernias, cysts, abscess, etc.)
[If the answer to this question is yes, no further questions are required.] Y N
- Is the patient greater than or equal to 18 years of age? Y N
- Does the patient have a diagnosis of chronic idiopathic constipation (constipation for more than six months not due to any other identifiable disease or drug)?
[If the answer to this question is yes, no further questions are required.] Y N
- Is Amitiza being used to treat irritable bowel syndrome with constipation (IBS-C) in women? Y N

Comments: _____

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

Prescriber's Signature:	Date:
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