

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 at least 2 years of age with a diagnosis of chronic iron overload?
[If the answer to this question is no, no further questions are required.] Y N
2. Is the iron overload due to blood transfusions (transfusional hemosiderosis)?
[If the answer to this question is no, no further questions are required.] Y N
3. Is the patient currently receiving Exjade therapy?
[If the answer to question is yes, skip to question 5.] Y N
4. Does the patient have a consistent serum ferritin level of greater than 1000 mcg/L?
[If the answer to this question is yes, skip to question 7.]
[If the answer to this question is no, no further questions are required.] Y N
5. Does the patient have a serum ferritin level less than 500 mcg/L?
[If the answer to this question is no, skip to question 7.] Y N
6. Will the prescriber consider temporarily interrupting therapy with Exjade?
[If the answer to this question is no, no further questions are required.] Y N
7. Will the serum ferritin level be monitored monthly for the duration of therapy? Y N

EXJADE

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Comments: _____

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

Prescriber's Signature:	Date:
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