

REBIF TITRTN (MEDICARE DETERMINATION)

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 866-692-2630.

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 physician purchasing and providing the drug "incident to" physician services? Y N
2. Is Rebif prescribed for the first clinical episode of MS?
[If the answer to this question is no, skip to question 4.] Y N
3. Did the patient have an MRI scan that demonstrated features consistent with a diagnosis of MS (i.e., multifocal white matter disease)?
[No further questions are required.] Y N
4. Does the patient have a diagnosis of a relapsing form of MS?
 - For example: relapsing-remitting MS, progressive-relapsing MS or secondary progressive MS WITH relapses Y N

Comments: _____

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

Prescriber's Signature:	Date:
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