

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 completed, please fax to Caremark at 1-888-836-0730.

This fax machine is located 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 1-800-294-5979 with any questions concerning prior authorization procedures.

- Does the patient have a diagnosis of pulmonary arterial hypertension? Y N
- Is the pulmonary hypertension associated with any of the following?:
 - Left Heart Disease
 - Chronic Thrombotic Disease
 - Embolic Disease
 - Compression of Pulmonary Vessels (e.g., adenopathy, tumor, fibrosing mediastinitis)
 - Lung Diseases and/or Hypoxemia (e.g., COPD; sleep disorders)
 - Sarcoidosis Y N
- Does the patient require nitrate therapy on a regular OR on an intermittent basis? Y N

Comments: _____

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