

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 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 patient greater than or equal to 16 years of age? Y N
2. Does the patient have the diagnosis of opioid dependence? Y N
3. Is the physician prescribing the drug for induction phase? Y N
4. Will the daily dose exceed 32 mg per day? Y N
5. Is the prescriber certified through SAMHSA (Substance Abuse and Mental Health Services Administration) to prescribe Suboxone and Subutex?
[If the answer to this question is yes, what is the registration number?] Y N
6. Is the prescriber treating more than 100 patients at a given time? Y N

SUBUTEX

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross[®] BlueShield[®] of South Carolina

7. Is the prescriber willing to follow safety precautions for treatment (e.g., avoid misuse and concomitant use of other CNS depressants, including benzodiazepines)? Y N
8. Is the patient willing to comply with treatment? Y N
9. Is the prescription for Suboxone or Subutex part of an overall treatment program (e.g., self-help groups, counseling, provide ongoing care, vocational training)? Y N
10. Will the physician reassess the progress of the patient periodically (e.g., relapse, progress/accomplishment of treatment goals)? Y N

Comments: _____

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

Prescriber's Signature:	Date:
--------------------------------	--------------