

ANDROGEL

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.

1. Is the patient a male? Y N
[If the answer to this question is no, then no further questions are required.]
2. Does the patient have confirmed or suspected carcinoma of the prostate or breast? Y N
3. Is the patient being treated for primary hypogonadism (congenital or acquired)? Y N
[If the answer to this question is yes, then skip to question 5]
4. Is the patient being treated for secondary (i.e. hypogonadotropic) hypogonadism (e.g., idiopathic gonadotropin or LHRH deficiency)? Y N
[If the answer to this question is no, then no further questions are required.]
5. Before the start of testosterone therapy did the patient (or does the patient current) have a confirmed low testosterone level (i.e. morning total testosterone less than 300 ng/dL, morning free or bioavailable testosterone less than 4 ng/dL) or absence of endogenous testosterone? Y N

ANDROGEL

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross BlueShield of South Carolina

Comments: _____

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

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