

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 there a neoplasm at the intended site of application?
[If the answer to this question is yes, then no further questions required.] Y N
2. Does patient have the diagnosis of diabetic neuropathic ulcer of the lower extremity? Y N
3. Has the ulcer been treated with Regranex for 3 months?
[If the answer to question is no, then skip to question 6.] Y N
4. Did the ulcer size good ulcer decrease by at least 30% in the first 10 weeks of therapy? Y N
5. Has the ulcer been treated with Regranex for 20 weeks?
[No further questions required.] Y N
6. Does the ulcer extend into the subcutaneous tissue or beyond? Y N

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7. Did the ulcer have an adequate blood supply? Y N
8. Are the good ulcer care practices being performed (including initial sharp debridement, and pressure relief)? Y N
9. Does the ulcer being treated have an active wound related infection?
[If the answer to this question is no, then no further questions required.] Y N
10. Is the wound infection under control by way of active treatment? Y N

Comments: _____

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

Prescriber's Signature: 	Date:
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