

SOMATULINE DEPOT INJECTION

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 1-888-836-0730.

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 1-800-294-5979 with any questions concerning prior authorization procedures.

1. Is the physician purchasing and providing the drug "incident to" physician services? Y N
2. Does the patient have a diagnosis of acromegaly? Y N
3. Is surgery and/or radiotherapy a therapeutic option for the patient?
[If the answer to this question is no, then no further questions are required.] Y N
4. Has the patient had an inadequate response to surgery and/or radiotherapy? Y N

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Comments: _____

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

Prescriber's Signature:	Date:
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