

SOMAVERT (MEDICARE DETERMINATION)

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 medication meet the Medicare definition of a drug or biological (e.g., the drug appears in the latest edition of the USP-NF or American Dental Association guide to dental therapeutics)? Y N
- Is this an injectable formulation of the drug? Y N
- Is the patient enrolled in Medicare Part B? Y N
- Has this drug claim been submitted through Medicare Part B? Y N
- Was the drug claim denied by Medicare Part B? Y N
- Is the drug excluded from Medicare benefit coverage (e.g., immunizations, antigens)? Y N

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7. Is the drug delivered through intravenous administration? Y N
8. Is the drug administered through an implantable pump? Y N
9. Is the drug administered through an external pump? Y N
10. Is the drug included under a local coverage policy for the applicable Medicare DMERC? Y N
11. Is the drug generally self-injected by a patient more than 50% of the time in an outpatient setting? Y N
12. Is the physician purchasing and providing the drug "incident to" physician services? Y N
13. Is the patient 18 years of age or older? Y N
14. Does the patient have a diagnosis of acromegaly? Y N
15. Had the patient received therapy with Somavert for the past 6 months under an administered benefit? Y N
16. Has the patient demonstrated a significant decrease in insulin-like growth factor-1 (IGF-1) levels with Somavert therapy? Y N
17. Has the patient received any of the following therapies for acromegaly: surgery, radiation therapy, or medical treatment? Y N
18. Did the patient have an inadequate response to the therapy? Y N
19. Have other treatments for acromegaly been considered? Y N
20. Does the patient have insulin-like growth factor (IGF-1) levels above the age and gender adjusted normal ranges? Y N

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21. Will the patient have IGF-1 levels monitored at 6 month intervals after IGF-1 levels stabilize within the normal range?

 Y N

22. Will the liver function tests be monitored as recommended during the therapy with Somavert?

 Y N

Comments: _____

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

Prescriber's Signature: 	Date:
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