

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
2. Is the patient being treated for primary hypogonadism (congenital or acquired)?
[If answer to this question is yes, may skip to question 4.] Y N
3. Does the patient have a diagnosis of hypogonadotropic hypogonadism (e.g., idiopathic gonadotropin or LHRH deficiency)? Y N
4. Before the start of testosterone therapy did the patient (or does the patient currently) have a confirmed low testosterone level (i.e. total testosterone less than 300 ng/dL, free or bioavailable testosterone less than 5 ng/dL) or absence of endogenous testosterone? Y N
5. Does the patient have breast cancer? Y N
6. Does the patient have prostate cancer? Y N

Comments: _____

Confidential

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Effective: 04/11/2008

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MedBlueRXSM and MedBlue RX PlusSM

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

Prescriber's Signature:	Date:
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