

**PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM**  
**BlueChoice® HealthPlan**

<b>Patient Information</b>	
<b>Name:</b>	<b>Insurance ID #:</b>
<b>Address:</b>	<b>Birthdate:</b>

<b>Provider Information</b>	
<b>Physician's Name:</b>	<b>Physician DEA #:</b>
<b>Phone:</b>	<b>Fax:</b>
<b>Office Address:</b>	
<b>Diagnosis:</b>	<b>ICD-9 Code:</b>

**When this form is completed, please fax back to Caremark at 1-888-836-0730.**

This fax machine is located in a HIPAA-compliant, secure location.  
 Call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures.  
*On behalf of BlueChoice HealthPlan, Caremark assists in the administration of this program.  
 Caremark is an independent company that administers prescription drug benefits.*

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|---|----------------------------|----------------------------|
| 1. Is the patient less than 40 years of age?<br>[If the answer to this question is no, then no further questions are required.]   | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 2. Does the patient have a history of symptomatic benign prostatic hyperplasia (BPH)?<br>(Examples of symptoms include: recurrent hematuria, nocturia, urinary frequency and/or urgency.) | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 3. Does the patient have an enlarged prostate gland as estimated by digital rectal examination or ultrasound?   | <input type="checkbox"/> Y | <input type="checkbox"/> N |

**Comments:** \_\_\_\_\_

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

<b>Prescriber's Signature:</b>	<b>Date:</b>
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