

**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.*

- |  |                            |                            |
|--|----------------------------|----------------------------|
| 1. Is the patient > 18 years of age?   | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 2. Does the patient have the diagnosis type 1 or type 2 diabetes mellitus?                                     | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 3. Is the patient currently receiving maximal insulin therapy?   | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 4. Is the patient compliant with their current insulin regimen?  | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 5. Has the patient received Symlin in the previous 6 months?<br>[If the answer is Yes, then go to question 7.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 6. Has the patient failed to achieve adequate glucose control?   | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 7. Is the patient compliant with self-blood glucose monitoring?  | <input type="checkbox"/> Y | <input type="checkbox"/> N |

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### BlueChoice<sup>®</sup> HealthPlan

- |   |  |                            |                            |
|---|--|----------------------------|----------------------------|
| 8. In the past 6 months, has the patient had a Hemoglobin A1c level > 9%?                             |  | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 9. Has the patient experienced severe hypoglycemia that required assistance during the past 6 months? |  | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 10. Does the patient have a confirmed diagnosis of gastroparesis?                                     |  | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 11. Does the patient require drug therapy to stimulate gastrointestinal motility?                     |  | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 12. Does the patient experience hypoglycemia unawareness?   |  | <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> |
|--------------------------------|--------------|