

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM
BlueChoice® HealthPlan

Patient Information	
Name:	Insurance ID #:
Address:	Birthdate:

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

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

This fax machine is located in a HIPAA-compliant, secure location.

Call Caremark at 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 2 years of age?
[If the answer to this question is yes, then no further questions are required.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 2. Is Singulair being requested for allergic rhinitis?
[If the answer to this question is yes, then skip to question 11.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 3. Is Singulair being requested to treat exercise-induced bronchospasm (EIB) and asthma classified as moderate-persistent or worse?
[If the answer to this question is yes, then skip to question 8.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 4. Is Singulair being requested to treat exercise-induced bronchospasm (EIB) and asthma classified as mild-persistent?
[If the answer to this question is yes, then skip to question 6.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 5. Is Singulair being requested to treat exercise-induced bronchospasm (EIB) alone?
[If the answer to this questions is no, then skip to question 7.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 6. Will Singulair be used as an adjunct therapy with a short-acting bronchodilator in the treatment of exercise-induced bronchospasm?
[No further questions are required.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 7. Is Singulair being requested to treat asthma alone?
[If the answer to this question is yes, then skip to question 9.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 8. Will Singulair be used as an adjunct therapy with a short-acting bronchodilator in the treatment of exercise-induced bronchospasm? | <input type="checkbox"/> Y | <input type="checkbox"/> N |

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9. Has the patient's inability to comply with inhaled corticosteroid treatment due to age, physical disability, illness, poor inhaler technique, etc. been documented? Y N
10. Has failure of inhaled corticosteroids to control symptoms while using a spacer device been documented? Y N
[No further questions are required.]
11. Does the patient have a documented contraindication OR a documented trial and failure of a 2nd generation antihistamine (OTC or prescription) AND an intranasal corticosteroid? Y N

Comments: _____

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

Prescriber's Signature:	Date:
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