

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 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. Does the patient have severely impaired liver function? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 2. Does the patient have severely impaired kidney function? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 3. Is the patient currently taking methotrexate? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 4. Is the patient currently taking tetracycline? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 5. Does the patient have the diagnosis of severe psoriasis?
[If the answer to this question is yes, then skip to question 9.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 6. Does the patient have a diagnosis of keratinization disorder?
[If the answer to this question is yes, then skip to question 9.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 7. Does the patient have a diagnosis of lichen planus?
[If the answer to this question is yes, then skip to question 9.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 8. Does the patient have a diagnosis of pityriasis rubra pilaris?
[If the answer to this question is no, then no further questions are required.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 9. Is the patient a male or a female not of child bearing potential?
[If the answer to this question is yes, then no further questions are required.] | <input type="checkbox"/> Y | <input type="checkbox"/> N |

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10. Has the patient been receiving Soriatane as a BlueChoice HealthPlan administered pharmacy benefit for at least 6 months?
[If the answer to this question is yes, then skip to question 12.] Y N
11. Has the patient been compliant with her chosen contraceptive plan?
[No further questions are required.] Y N
12. Is the patient unresponsive to other typical therapies for this diagnosis excluding injectable or infusible medications?
[If the answer to this question is yes, then skip to question 14.] Y N
13. Are other typical therapies other than injectable or infusible medications for the treatment of this diagnosis contraindicated due to the clinical condition of the patient? Y N
14. Has pregnancy been excluded as confirmed by 2 negative urine or serum pregnancy tests with a sensitivity of at least 25 mIU/mL? Y N
15. Has the patient chosen to use any of the following methods of contraception?
 - One primary form (e.g., tubal ligation, partner's vasectomy, intrauterine devices, birth control pills, injectable/implantable/insertable/topical hormonal birth control products) **plus** one secondary form (e.g., diaphragms, latex condoms, cervical caps) used in combination with a spermicide. Y N
 - Absolute abstinence
16. Has the patient agreed to use her chosen form of contraception for at least 1 month before initiation of Soriatane therapy, during Soriatane therapy, and for at least 3 years after discontinuation of therapy? Y N
17. Has the patient been advised that ethanol must not be ingested by female patients during Soriatane treatment and for 2 months following therapy? Y N
18. Will the patient have a negative pregnancy test on a monthly basis?
[If the answer to this question is no, then no further questions are required.] Y N
19. Did the female patient or guardian sign a Patient Agreement/Informed Consent? Y N

Comments: _____

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

Prescriber's Signature: 	Date:
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