Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Prior Authorization Form

Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Acetylcysteine Inhal Soln (Medicare B vs D)
This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at **1-888-836-0730**.
Please contact CVS|Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Acetylcysteine Inhal Soln (Medicare B vs D).

Drug Name (select from list of drugs shown)
Acetylcysteine Inhalant Solution

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each applicable question.

1. Has the patient received a nebulizer machine covered through the Medicare benefit? Y N

Comments: _____

I affirm that the information given on this form is true and accurate as of this date.

_____
Prescriber (Or Authorized) Signature and Date