

Prior Authorization Form
Date Criteria: 12/21/2006

CAREFIRST BLUECROSS BLUESHIELD

Cesamet

Complete information, sign and date. Fax completed forms to Argus at 1-800-315-4025.
This fax machine is located in a secure location as required by HIPAA regulations.

When conditions are met, we will authorize coverage of Cesamet.
Please contact Argus at 1-800-314-2872 with questions regarding the prior authorization process.

Patient:

Patient Name: _____
Patient ID: _____
Patient's Group Number: _____
Patient's Date of Birth: _____

Prescribing Physician:

Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Prescriber ID: _____
Physician Address: _____
Physician City, State, Zip: _____

1. Is the prescribing physician an oncologist? **Y** **N**
2. Is Cesamet being used for chemotherapy-induced nausea and vomiting? **Y** **N**
If no, please specify diagnosis _____
3. Has the patient tried and failed other therapies? **Y** **N**
If yes, please provide the names of the drugs used.

Comments:

Information given on this form is accurate as of this date.

Prescriber or Authorized Signature

Date