



Fax Referral To: 800-323-2445

Phone: 866-278-6634

Temodar® (temozolomide) Enrollment Form For Blue Cross Blue Shield of Rhode Island Members

Date: _____ Needs by Date (Please Specify): _____

Ship to: Patient Office Other: _____

PATIENT INFORMATION

(Complete the following or send patient demographic sheet)

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Insurance ID: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____
Contact Phone: _____

INSURANCE INFORMATION (If available, please copy and attach the front and back of insurance and prescription drug card)

Primary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: **Blue Cross Blue Shield of RI**
Secondary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 code): 191.9 Glioma (Malignant), Astrocytic, Unspecified Site Other: _____ • Date of Diagnosis: _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas that are not filled out will be considered not applicable for your patient & MAY AFFECT THE OUTCOME of this request.

- Patient has a diagnosis of esophageal stricture. Yes No
- Patient has diagnosis of glioblastoma multiforme. Yes No
- Patient has a diagnosis of refractory anaplastic astrocytoma. Yes No
- Patient has had a disease progression while treated with procarbazine (Matulane) and 1 nitrosourea including but not limited to: Yes No
 - Carmustine (BiCNU)
 - Lomustine (CeeNU)
- Patient has a diagnosis of metastatic melanoma. Yes No

Note: The following compendia, American Hospital Formulary Service, U.S. Pharmacopeia Dispensing Information, National Comprehensive Cancer Network (NCCN), and Drug & Biologics Compendium™ Category of Evidence and Consensus are considered during prior authorization review if the drug is being prescribed for a condition not listed above. Additional information may be requested if documentation in the compendia is lacking.

Medical Necessity (please attach all supporting documentation):

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Temodar® (temozolomide)	<input type="checkbox"/> 5mg:	Take _____ capsules po QD with a full glass of water for _____ days with _____ days off.	_____	5mg
	<input type="checkbox"/> 20mg:	Take _____ capsules po QD with a full glass of water for _____ days with _____ days off.	_____	20mg
	<input type="checkbox"/> 100mg:	Take _____ capsules po QD with a full glass of water for _____ days with _____ days off.	_____	100mg
	<input type="checkbox"/> 140mg:	Take _____ capsules po QD with a full glass of water for _____ days with _____ days off.	_____	140mg
	<input type="checkbox"/> 180mg:	Take _____ capsules po QD with a full glass of water for _____ days with _____ days off.	_____	180mg
	<input type="checkbox"/> 250mg:	Take _____ capsules po QD with a full glass of water for _____ days with _____ days off.	_____	250mg
Total Daily Dosage: _____ mg				

PRODUCT SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN

(Date)

IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. Temodar PAB 092908