Fax Referral To: 800-323-2445
Phone: 866-278-6634

Caprelsa®(vandetanib)
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 (*Please copy and attach the front and back of insurance and prescription drug card*)

Prescription Card:	Name of Insurer:	ID#:	BIN:	PCN:	Group:
Primary Insurance:	Subscriber:	ID#:	Name of Insurer: **Blue Cross Blue Shield of RI**		Phone:
Secondary Insurance:	Subscriber:	ID#:	Name of Insurer:		Phone:

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 Code): ☐ Other: ____________ • Date of Diagnosis: ________

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

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

- Patient has a diagnosis of medullary thyroid cancer? ☐ Yes ☐ No
- Is the thyroid cancer symptomatic or progressive? ☐ Yes ☐ No
- Patient has unresectable locally advanced or metastatic disease? ☐ Yes ☐ No
- Patient has hypocalcemia, hypokalemia or hypomagnesemia? ☐ Yes ☐ No
- Will the hypocalcemia, hypokalemia or hypomagnesemia be corrected prior to Caprelsa administration? ☐ Yes ☐ No
- Patient has long QT syndrome? ☐ Yes ☐ No
  - If yes, will the ECG be monitored according to recommendations provided in the prescribing information for Caprelsa? ☐ Yes ☐ No
- Patient is receiving any drugs known to prolong the QT interval? ☐ Yes ☐ No
  - If yes, will the ECG be monitored more frequently than recommended for patients not receiving QT-prolonging drugs? ☐ Yes ☐ No

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Caprelsa® (vandetanib)				

X ______________________________
PRODUCT SUBSTITUTION PERMITTED (Date)

X ______________________________
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. Caprelsa PAB 072811*