CVS CAREMARK

**Fax Referral To: 800-323-2445**

**Phone: 866-278-6634**

# Cerezyme and VPRIV
## 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):** ☐ _____ • Date of Diagnosis: _____

**APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.**

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

- What is the prescribed medication? ☐ Cerezyme ☐ VPRIV ☐ Other
- Does the patient have a confirmed diagnosis of Gaucher disease? ☐ Yes ☐ No
- Which variant of Gaucher disease does the patient have? ☐ Type 1 ☐ Type 2 ☐ Type 3
- Does the patient have one or more of the following complications of Gaucher disease? ☐ Yes ☐ No
  - If Yes, Please indicate which complication(s) the patient has:
    - ☐ Anemia
    - ☐ Thrombocytopenia
    - ☐ Bone disease
    - ☐ Hepatomegaly or splenomegaly
    - ☐ Developmental delay
    - ☐ Ophthalmoplegia (gaze palsy)
    - ☐ Other: _____

### PRESCRIPTION INFORMATION

| MEDICATION | STRENGTH | DIRECTIONS | QUANTITY | REFILLS |
|---|---|---|---|---|
| ☐ | | | | |

_____ _____

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)