



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
<input type="checkbox"/>				

PRODUCT SUBSTITUTION PERMITTED \_\_\_\_\_ (Date)

DISPENSE AS WRITTEN \_\_\_\_\_ (Date)

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