CVS CAREMARK

Fax Referral To: 800-323-2445

Phone: 866-278-6634

Leuprolide Depot for Prostate Cancer
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: _____
Last Four of SS #: _____ Primary Language: _____
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: _____ 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: _____ • Date of Diagnosis: _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Non-Preferred Leuprolide Depot for prostate cancer requires a trial of Eligard.

Preferred Leuprolide Depot

☐ Eligard® 7.5 mg, 22.5 mg, 30 mg, and 45 mg

Non-Preferred Leuprolide Depot

☐ Lupron® Depot 7.5 mg, 22.5 mg, 30 mg, and 45 mg

Note: Does not apply to other strengths of leuprolide, Lupron Depot or Lupron Depot-PED

*****Referrals for leuprolide injection (1 mg/0.2 mL), Lupron Depot 3.75 mg, 11.25 mg, or Lupron Depot-PED do not require any additional information.*****

• Does the patient have a diagnosis of prostate cancer? ☐ Yes ☐ No

• Did the patient have an inadequate response to Eligard (eg, unable to maintain castrate levels of testosterone)? ☐ Yes ☐ No

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Eligard®	☐ 7.5 mg ☐ 22.5 mg ☐ 30 mg ☐ 45 mg			

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