



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
<input type="checkbox"/> Eligard®	<input type="checkbox"/> 7.5 mg <input type="checkbox"/> 22.5 mg <input type="checkbox"/> 30 mg <input type="checkbox"/> 45 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. Eligard PAB 100411