CVS CAREMARK

Fax Referral To: 800-323-2445

Phone: 866-278-6634

Gilenya® (fingolimod)
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): ☐ 340 Multiple Sclerosis ☐ 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 diagnosis is Multiple Sclerosis ☐ Yes ☐ No
- Patient has relapsing form of MS ☐ Yes ☐ No
- Patient will receive Gilenya concurrently with antineoplastic, immunosuppressive or immune modulating therapy? ☐ Yes ☐ No
- Patient will receive Gilenya concurrently with a biologic agent for MS ☐ Yes ☐ No
- Patient has had the following tests performed within 6 months prior to starting Gilenya therapy with normal results

  ☐Electrocardiogram (ECG) ☐ Complete blood count (CBC) ☐Liver function tests (LFTs)
- Patient has a history of diabetes or uveitis ☐ Yes ☐ No

  If Yes, was an ophthalomolgic exam performed within 6 months prior to starting Gilenya therapy ☐ Yes ☐ No
- Patient has a history of chickenpox ☐ Yes ☐ No

  If No, was the patient vaccinated against varicella zoster virus (VZV) ☐ Yes ☐ No

  If No, was immunity to varicella confirmed with VZV antibody testing ☐ Yes ☐ No
- Will (was) patients first dose of Gilenya administered under health care provider supervision ☐ Yes ☐ No
- Patient was observed for a minimum of 6 hours following the first dose of Gilenya for signs/symptoms of bradycardia ☐ Yes ☐ No

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Gilenya (fingolimod)				

X _____
PRODUCT SUBSTITUTION PERMITTED (Date)

X _____
DISPENSE AS WRITTEN (Date)