CVS CAREMARK

Fax Referral To: 800-323-2445

Phone: 866-278-6634

H.P. Acthar® Gel (corticotropin)
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

Please note: Any areas that are not filled out will be considered not applicable to your patient and MAY AFFECT THE OUTCOME OF THIS REQUEST

- Medication will be used for diagnostic testing of adrenocortical function ☐ Yes ☐ No
- Medication will be used as treatment of West syndrome (infantile spasms) ☐ Yes ☐ No
- Medication will be used as treatment of multiple sclerosis, acute exacerbations ☐ Yes ☐ No
- Patient has had a failure of corticosteroid therapy ☐ Yes ☐ No

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ H.P. Acthar® Gel (corticotrophin)	☐ 80 units/mL			

_____ PRODUCT SUBSTITUTION PERMITTED (Date)

_____ DISPENSE AS WRITTEN (Date)