



Fax Referral To: 800-323-2445

Phone: 866-278-6634

# Hizentra<sup>®</sup> and Vivaglobin<sup>®</sup>

## 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

- What is the diagnosis?  Primary immune deficiency
- Common variable immunodeficiency
- Congenital agammaglobulinemia (X-linked agammaglobulinemia)
- Hypogammaglobulinemia
- Severe combined immunodeficiency
- Wiskott-Aldrich syndrome
- X-linked immunodeficiency with hyperimmunoglobulin M
- Other: \_\_\_\_\_

### PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Vivaglobin <sup>®</sup>			(per 30 days)	
<input type="checkbox"/> Hizentra <sup>®</sup>				

PRODUCT SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN

(Date)

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