



Fax Referral To: 800-323-2445

Phone: 866-278-6634

Lucentis™ (ranibizumab)
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: _____
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): ☐ 362.16 Choroidal Neovascularization ☐ 362.52 Exudative Senile Macular Degeneration • Date of Diagnosis: _____
☐ 362.50 Macular Degeneration (Senile) ☐ Other: _____

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.

- Are symptoms of ocular or peri-ocular infection present ☐ Yes ☐ No
- Does the patient have a diagnosis of established neovascular ("Wet") aged-related macular degeneration (AMD)? ☐ Yes ☐ No
- Is the patient currently on Lucentis therapy for neovascular AMD? ☐ Yes ☐ No
 - If yes, how long has the patient been on therapy? _____
 - Is there continued CNV activity based on fluorescein angiogram or OCT exam? ☐ Yes ☐ No
- Does the patient have a diagnosis of macular edema due to retinal vein occlusion? ☐ Yes ☐ No

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Lucentis™ (ranibizumab)	0.5 mg (0.05ml) glass syringe (for intravitreal injection)	<input type="checkbox"/> Prepare and administer 0.05ml (0.5mg) by intravitreal injection every 4 weeks <input type="checkbox"/> Other: _____	<input type="checkbox"/> One 0.2ml vial kit (4-week supply) <input type="checkbox"/> Other: _____	<input type="checkbox"/> 11 (1-year supply) <input type="checkbox"/> _____

X

PRODUCT SUBSTITUTION PERMITTED

(Date)

X

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. Lucentis PAB 010312