



Fax Referral To: 800-323-2445

Phone: 866-278-6634

**Macugen® (pegaptanib)**  
**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)

<b>Prescription Card:</b>	Name of Insurer: _____	ID#: _____	BIN: _____	PCN: _____	Group: _____
<b>Primary Insurance:</b>	Subscriber: _____	ID#: _____	Name of Insurer: <b>Blue Cross Blue Shield of RI</b>	Phone: _____	
<b>Secondary Insurance:</b>	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") age-related macular degeneration (AMD) ☐ Yes ☐ No
- Is the patient currently on Macugen 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

**PRESCRIPTION INFORMATION**

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> Macugen® (pegaptanib)	0.3 mg/ml glass syringe (for intravitreal injection)	<input type="checkbox"/> Administer 0.3mg intravitreally once every 6 weeks into the eye to be treated  <input type="checkbox"/> Other: _____	<input type="checkbox"/> One 0.3mg syringe (6-week supply)  <input type="checkbox"/> Other: _____	<input type="checkbox"/> 9 (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. Macugen PAB 010312