CVS CAREMARK

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)*

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 Chorodial 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
☐ Macugen® (pegaptanib)	0.3 mg/ml glass syringe *(for intravitreous injection)*	☐ Administer 0.3mg intravitreously once every 6 weeks into the eye to be treated ☐ Other: _____	☐ One 0.3mg syringe *(6-week supply)* ☐ Other: _____	☐ 9 *(1-year supply)* ☐ _____

X _____ X _____
PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)