



Fax Referral To: 800-323-2445
 Phone: 866-278-6634

NPlate (romiplostim) 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

- Patient has a diagnosis of chronic immune (idiopathic) thrombocytopenic purpura (ITP) – ITP refers to long term low platelet counts (<50,000/mm³), and there is no known cause for the low platelet counts. Yes No
- Patient has had previous treatment failure with one of the following interventions:
 Corticosteroids Immunoglobulins Splenectomy Other: _____
- Patient is at risk for bleed as a result of thrombocytopenia and clinical condition. Yes No

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/> NPlate (romiplostim)	<input type="checkbox"/> 250mg <input type="checkbox"/> 500mg			

PRODUCT SUBSTITUTION PERMITTED _____ (Date)

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. NPlate PAB 051109