



Fax Referral To: 800-323-2445

Phone: 866-278-6634

# Oforta 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.

**NOTE: Any areas that are not filled out will be considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.**

- Is the patient an adult with B-cell chronic lymphocytic leukemia?  Yes  No
- Will the patient receive concurrent therapy with Nipent (pentostatin) while taking Oforta?  Yes  No
- If new to therapy, has the patient not responded to or experienced disease progression during or after an alkylating agent-containing regimen?  Yes  No
- Has the patient previously received or is the patient currently on Oforta therapy?  Yes  No
  - If yes, Is the patient exhibiting signs or symptoms consistent with neurotoxicity or bone marrow suppression (including evidence of hemolysis, which may indicate autoimmune hemolytic anemia)?  Yes  No

### PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<input type="checkbox"/>				

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. Oforta PAB 072710