<b>CVS</b> CAREMA <b>R</b> K		Myozyme and Lumizyme (alglucosidase alfa) Enrollment Form For Blue Cross Blue Shield of Rhode Island Members			
Fax Referral To: 800-323-2	2445				
Phone: 866-278-6634 Date:		Needs by Date (Please Specify):			
Ship to: 🗌 Patient 🗌 Office 🗌 Ot	her:				
PATIENT INFORMA	ATION	PRESCRIBER INFORMATION			
(Complete the following or send patient demographic sheet)		Prescriber's Name:			
Patient Name:		State License #:	UPIN:		
Address:		DEA #:	NPI #:		
City, State, Zip:		Group or Hospital:			
Home Phone:		Address:			
Alternate Phone:		City, State Zip:			
SS #:		Phone:	Fax:		
Insurance ID:		Contact Person:			
Date of Birth: G	ender:	Contact Phone:			
INSURANCE IN	FORMATION (Please copy	and attach the front and back of insure	ance and prescription drug car	rd)	
Prescription Card: Name of Insurer:	ID#	: BIN:	PCN:	Group:	
Primary Insurance: Subscriber:	ID#		: Blue Cross Blue Shield of RI	Phone:	
Secondary Insurance: Subscriber:	ID#	· · · · · · · · · · · · · · · · ·		Phone:	
STATEN	IENT OF MEDICAL	NECESSITY for BCBS of Rh	ode Island Members		
Diagnosis (ICD-9 Code):			Date of Diagnosis:		
APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.					
NOTE: Any areas that are not filled out	t will be considered not a	pplicable to your patient & MAY	AFFECT THE OUTCO	ME of this request.	
• Patient has a diagnosis of Pompe disease					
• Diagnosis confirmed by GAA* enzyme activity testing or DNA testing			🗌 Yes 🗌 No		
• Patient will be pretreated with antihistamines and/or antipyretics prior to infusions					
<b>Note:</b> GAA = acid a-glucosidase					
PRESCRIPTION INFORMATION					
MEDICATION S	FRENGTH	DIRECTIONS	QUAN	TITY REFILLS	
Myozyme					
PRODUCT SUBSTITUTION PERMITTED		Date) DISPENSE AS WRITTED	N	(Date)	

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