CVS CAREMARK

Fax Referral To: 800-323-2445

Phone: 866-278-6634

Sabril
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.

- What is the diagnosis? ☐ Infantile spasms ☐ Complex partial seizures (CPS) ☐ Other _____
- How old is the patient? (in Months or Years) _____
- Was the vision assessed at baseline, or will the vision be assessed by an ophthalmologist no longer than 4 weeks after starting Sabril? ☐ Yes ☐ No
- Is the patient at high risk for having, or does the patient have other types of irreversible vision loss? ☐ Yes ☐ No
- Is the patient using other medications associated with serious adverse ophthalmic effects such as retinopathy or glaucoma? ☐ Yes ☐ No
- If Diagnosis is Infantile spasms, is Sabril being used as monotherapy? ☐ Yes ☐ No
- If Diagnosis is Complex partial seizures, is Sabril being used as adjunctive therapy? ☐ Yes ☐ No
- Is the patient refractory to other antiepileptic drugs? ☐ Yes ☐ No
- Has the patient inadequately responded to either carbamazepine or phenytoin or does the patient have an intolerance or contraindication to these regimens? ☐ Yes ☐ No
- Is the patient currently on Sabril therapy? ☐ Yes ☐ No
  - If yes, has the patient shown substantial clinical benefit from Sabril therapy? ☐ Yes ☐ No
  - If yes, will the patient's vision be assessed every 3 months by an ophthalmologist? ☐ Yes ☐ No

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐				

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