



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
<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. Sabril PAB 072710