CVS CAREMARK Fax Referral To: 800-323-2445		Sylatron [™] (peginterferon alfa-2b) Enrollment Form For Blue Cross Blue Shield of Rhode Island Members				
Phone: 866-278-6634		Date:	Needs by Date (Please Specify):			
Ship to: Patient Off		Datt.		ate (1 lease oper	<u> </u>	
	INFORMATION		PRESC	CRIBER INFORMATIO)N	
(Complete the following or send patient demographic sheet)			Prescriber's Name:			
Patient Name:		<u>, , , , , , , , , , , , , , , , , , , </u>	State License #:	UPIN:		
Addrosse			DEA #:	NPI	#:	
City, State, Zip:		_	Group or Hospital:			<u> </u>
Home Phone:			Address:			
Alternate Phone:			City, State Zip:			
SS #:			Phone:	Fax:		
Insurance ID:			Contact Person:			
Date of Birth:	Gender:		Contact Phone:			
			and attach the front and back of insuran	, , ,		
•	of Insurer:	ID#:	BIN:	PCN:	Group:	
·	ubscriber:	ID#: 	Name of Insurer: Name of Insurer:	Blue Cross Blue Shield of RI	Phone:	
Secondary insurance: 5					Phone:	
		IEDICAL N	ECESSITY for BCBS of Rho	de Island Members		
Diagnosis (ICD-9 Code):	Other:		Date of Diagnosis:			
APPROVAL CRITERIA: CHE						
NOTE: Any areas not filled out	are considered not applical	ble to your pation	ent & MAY AFFECT THE OUTCO	ME of this request.		
• Does the patient have any of the	following contraindications t	to Sylatron thera	py?			
• Autoimmune hepatitis			Tes No			
Decompensated hepatic disease				Tes No		
• Uncontrolled major depression or severe mental illness				☐ Ye	s 🗌 No	
• Patient will be monitored and evaluated for signs and symptoms of depression and other psychiatric symptoms throughout treatment? 🗌 Yes 🗌 No						
• What is the diagnosis?						
Patient is currently receiving Sylatron for melanoma? Yes No						
• Did patient's melanoma have mi	croscopic or gross nodal invo	olvement?		Yes No		
• Patient has had surgical resection including complete lymphadenectomy?				Yes No		
• Is Sylatron being requested within 84 days (12 weeks) of surgical resection?				🗌 Ye	s 🗌 No	
		PRESCRI	PTION INFORMATION			
MEDICATION	STRENGTH		DIRECTIONS	QUAN	TITY	REFILLS
☐ Sylatron [™] (peginterferon alfa-2b)						
X	1	I	X	I		
PRODUCT SUBSTITUTION	I PERMITTED	(Da	tte) DISPENSE AS WRI	TTEN		(Date)

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