CVS CAREMARK

Fax Referral To: 800-323-2445

Phone: 866-278-6634

Sylatron™ (peginterferon alfa-2b)
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 (*Please copy and attach the front and back of insurance and prescription drug card)*

Prescription Card: Name of Insurer: _____ ID#: _____ BIN: _____ PCN: _____ Group: _____
Primary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: **Blue Cross Blue Shield of RI** Phone: _____
Secondary Insurance: Subscriber: _____ ID#: _____ Name of Insurer: _____ Phone: _____

STATEMENT OF MEDICAL NECESSITY for BCBS of Rhode Island Members

Diagnosis (ICD-9 Code): ☐ Other: _____ • Date of Diagnosis: _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

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

- Does the patient have any of the following contraindications to Sylatron therapy?
  - Autoimmune hepatitis ☐ Yes ☐ No
  - Decompensated hepatic disease ☐ Yes ☐ No
  - Uncontrolled major depression or severe mental illness ☐ Yes ☐ 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 microscopic or gross nodal involvement? ☐ Yes ☐ No
- Patient has had surgical resection including complete lymphadenectomy? ☐ Yes ☐ No
- Is Sylatron being requested within 84 days (12 weeks) of surgical resection? ☐ Yes ☐ No

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Sylatron™ (peginterferon alfa-2b)				

X _____
PRODUCT SUBSTITUTION PERMITTED (Date)

X _____
DISPENSE AS WRITTEN (Date)