



Fax Referral To: 800-323-2445

Phone: 866-278-6634

Temodar® (temozolomide) 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): 191.9 Glioma (Malignant), Astrocytic, Unspecified Site Other: Date of Diagnosis:

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

- NOTE: Any areas that are not filled out will be considered not applicable for your patient & MAY AFFECT THE OUTCOME of this request. Patient has a diagnosis of esophageal stricture. Patient has diagnosis of glioblastoma multiforme. Patient has a diagnosis of refractory anaplastic astrocytoma. Patient has had a disease progression while treated with procarbazine (Matulane) and 1 nitrosourea including but not limited to: Carmustine (BiCNU) Lomustine (CeeNU) Patient has a diagnosis of metastatic melanoma.

Note: The following compendia, American Hospital Formulary Service, U.S. Pharmacopeia Dispensing Information, National Comprehensive Cancer Network (NCCN), and Drug & Biologics Compendium™ Category of Evidence and Consensus are considered during prior authorization review if the drug is being prescribed for a condition not listed above. Additional information may be requested if documentation in the compendia is lacking.

Medical Necessity (please attach all supporting documentation):

PRESCRIPTION INFORMATION

Table with 5 columns: MEDICATION, STRENGTH, DIRECTIONS, QUANTITY, REFILLS. Includes Temodar (temozolomide) and dosage instructions.

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. Temodar PAB 092908