



Fax Referral To: 800-323-2445

Phone: 866-278-6634

Votrient® 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

Please note: Any areas that are not filled out will be considered not applicable to your patient and MAY AFFECT THE OUTCOME OF THIS REQUEST

- Is the patient currently receiving treatment with Votrient?  Yes  No
Does the patient have concurrent elevations of alanine transaminase (ALT) greater than 3x ULN with bilirubin greater than 2x ULN?  Yes  No

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.

PRESCRIPTION INFORMATION

Table with 5 columns: MEDICATION, STRENGTH, DIRECTIONS, QUANTITY, REFILLS. Row 1:  Votrient®

PRODUCT SUBSTITUTION PERMITTED

(Date)

DISPENSE AS WRITTEN

(Date)

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