



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Thalomid (Medicare Prior Authorization)**

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS|Caremark at 1-888-836-0730.
Please contact CVS|Caremark at 1-800-294-5979 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Thalomid (Medicare Prior Authorization).

Drug Name (select from list of drugs shown)

Thalomid (thalidomide)

Patient Information

Patient
Name: _____
Patient ID: _____
Patient
Group No.: _____
Patient
DOB: _____

Prescribing Physician

Physician
Name: _____
Physician
Phone: _____
Physician
Fax: _____
Physician
Address: _____
City, State,
Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each applicable question.

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|---|---|---|
| 1. Is the patient currently on Thalomid therapy?
[If the answer to this question is yes, then no further questions.] | Y | N |
| 2. Does the patient have a diagnosis of advanced, refractory multiple myeloma?
[If the answer to this question is yes, then may skip to question 16.] | Y | N |
| 3. Does the patient have a diagnosis of moderate to severe erythema nodosum leprosum (also known as ENL, Hanson's disease, or leprosy)?
[If the answer to this question is no, then may skip to question 6.] | Y | N |
| 4. Does the patient suffer from moderate to severe neuritis associated with ENL?
[If the answer to this question is no, then may skip to question 16.] | Y | N |
| 5. Will the patient be treated with Thalomid as monotherapy?
[If the answer to this question is yes, then no further questions.]
[If the answer is no, then may skip to question 16.] | Y | N |
| 6. Does the patient have a diagnosis of newly diagnosed multiple myeloma?
[If the answer to this question is no, then may skip to question 10.] | Y | N |



Arkansas BlueCross BlueShield

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|-----|--|---|---|
| 7. | Will Thalomid be used in combination with dexamethasone?
[If the answer to this question is yes, then may skip to question 16.] | Y | N |
| 8. | Will Thalomid be used in combination with melphalan and prednisone?
[If the answer to this question is no, then no further questions.] | Y | N |
| 9. | Is the patient elderly or transplant ineligible?
[If the answer to this question is yes, then may skip to question 16.]
[If the answer is no, then no further questions.] | Y | N |
| 10. | Does the patient have a diagnosis of mucocutaneous lesions associated with Behcet's syndrome?
[If the answer to this question is yes, then may skip to question 16.] | Y | N |
| 11. | Does the patient have a diagnosis of mantle cell lymphoma?
[If the answer to this question is no, then may skip to question 14.] | Y | N |
| 12. | Does the patient have relapsed, refractory, or progressive disease?
[If the answer to this question is no, then no further questions.] | Y | N |
| 13. | Will Thalomid be used in combination with rituximab?
[If the answer to this question is yes, then may skip to question 16.]
[If the answer is no, then no further questions.] | Y | N |
| 14. | Does the patient have a diagnosis of human immunodeficiency virus infection?
[If the answer to this question is no, then no further questions.] | Y | N |
| 15. | Does the patient have an aphthous ulcer of mouth or esophagus?
[If the answer to this question is no, then no further questions.] | Y | N |
| 16. | Is the patient male?
[If the answer to this question is yes, then may skip to question 19.] | Y | N |
| 17. | Is the patient female of childbearing potential?
[If the answer to this question is no, then may skip to question 20.] | Y | N |
| 18. | Has pregnancy been excluded as confirmed by two negative urine or serum pregnancy tests?
[If the answer to this question is no, then no further questions.] | Y | N |
| 19. | Has the patient been instructed regarding the importance and the proper utilization of appropriate contraceptive methods for Thalomid use?
[If the answer to this question is no, then no further questions.] | Y | N |
| 20. | Has the patient been informed of the need to be observant for the signs and symptoms of thromboembolism? (e.g., shortness of breath, chest pain, or arm or leg swelling) | Y | N |

Comments: _____

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date