

Pharmacy Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: Commercial (Traditional) Commercial (Individual/Optimized)
 Medicaid

This request is: Urgent (life threatening) Non-Urgent (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Thalomid[®] (thalidomide)

Member

Last Name: _____ First Name: _____
 ID #: _____ DOB: _____ Gender: _____
 Primary Care Physician: _____
 Requesting Provider: _____ Prov. Phone: _____ Prov. Fax: _____
 Provider Address: _____
 Provider NPI: _____ Contact Name: _____
 Provider Signature: _____ Date: _____

Product Information

New request Continuation request

Drug product: Thalomid 50 mg capsule **Start date** (or date of next dose): _____
 Thalomid 100 mg capsule **Date of last dose** (if applicable): _____
 Thalomid 150 mg capsule **Dose:** _____
 Thalomid 200 mg capsule **Frequency:** _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements:

1. Diagnosis of multiple myeloma; OR
2. Diagnosis of erythema nodosum leprosum

Note: Authorization for indications not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the drug's use for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

Multiple myeloma
 Erythema nodosum leprosum
 Other – the patient's condition is: _____
 Rationale for use: _____