

# THALOMID

(thialidomide)

## PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross BlueShield of South Carolina

Patient Information	
Name:	Insurance ID #:
Group#:	Birthdate:

Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

### When this form is complete, please fax to Caremark at 888-836-0730.

This fax machine is located in a HIPAA-compliant, secure location. On behalf of BlueCross BlueShield of South Carolina, Caremark assists in the administration of prescription drug programs. Caremark is an independent company that provides pharmacy benefits management.

Call Caremark at 800-294-5979 with any questions concerning prior authorization procedures.

1. Is the patient currently on Thalomid therapy?  
[If the answer to this question is yes, then no further questions are required.]  Y  N
2. Does the patient have a diagnosis of advanced, refractory multiple myeloma?  
[If the answer to this question is yes, then skip to question 14.]  Y  N
3. Does the patient have a diagnosis of moderate to severe erythema nodosum leprosum (also known as ENL, Hansen's disease, or leprosy)?  
[If the answer to this question is no, then 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 skip to question 14.]  Y  N
5. Will the patient be treated with Thalomid as monotherapy?  
[If the answer to this question is yes, then no further questions required.]  
[If the answer is no, then skip to question 14.]  Y  N

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6. Does the patient have a diagnosis of newly diagnosed multiple myeloma?  
[If the answer to this question is no, then skip to question 10.]  Y  N
7. Is the patient elderly or transplant ineligible?  
[If the answer to this question is yes, then skip to question 14.]  Y  N
8. Will Thalomid be used in combination with dexamethasone?  
[If the answer to this question is yes, then skip to question 14.]  
[If the answer is no, then no further questions required.]  Y  N
9. Will Thalomid be used in combination with melphalan and prednisone?  
[If the answer to this question is yes, then skip to question 14.]  
[If the answer is no, then no further questions required.]  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 skip to question 14.]  Y  N
11. Does the patient have a diagnosis of mantle cell lymphoma?  
[If the answer to this question is no, then no further questions are required.]  Y  N
12. Does the patient have relapsed, refractory, or progressive disease?  
[If the answer to this question is no, then no further questions required.]  Y  N
13. Will Thalomid be used in combination with rituximab?  
[If the answer to this question is no, then no further questions are required.]  Y  N
14. Is the patient male?  
[If the answer to this question is yes, then skip to question 17.]  Y  N
15. Is the patient female of childbearing potential?  
[If the answer to this question is no, then skip to question 18.]  Y  N
16. Has the 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 are required.]  Y  N
17. 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 are required.]  Y  N
18. 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:** \_\_\_\_\_

*Information on this form is accurate as of the date below.*

<b>Prescriber's Signature:</b>  	<b>Date:</b>  
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