Thalomid (thalidomide)
Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

☐ **URGENT**

MEMBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PHONE NUMBER:	**DATE OF BIRTH:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
PATIENT INSURANCE ID NUMBER:	

☐ **MALE** ☐ **FEMALE** **HEIGHT (IN/CM):** _____ **WEIGHT (LB/KG):** _____ **ALLERGIES:** _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION	
LAST NAME:	**FIRST NAME:**
PRESCRIBER SPECIALTY:	**EMAIL ADDRESS:**
NPI NUMBER:	**DEA NUMBER:**
PHONE NUMBER:	**FAX NUMBER:**
STREET ADDRESS:	
CITY:	**STATE:** **ZIP CODE:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL** DURATION OF THERAPY (SPECIFIC DATES):		**IF RENEWAL:** DATE THERAPY INITIATED:	

Continued on next page.

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MEMBER'S LAST NAME: _____ **MEMBER'S FIRST NAME:** _____

1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION? ☐ YES (if yes, complete below) ☐ NO		
MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE)**:**	**DURATION OF THERAPY** (SPECIFY DATES)**:**	**RESPONSE/REASON FOR FAILURE/ALLERGY:**

2. LIST DIAGNOSES:	**ICD-10:**
□ Cutaneous lupus □ Erythema nodosum leprosum (ENL) □ Gastrointestinal vascular malformation (Gastrointestinal angiodysplasia, Osler-Weber-Rendu syndrome) □ Multiple myeloma/plasmacytoma □ Myelofibrosis □ Other diagnosis: _____ICD-10_____	

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

For <u>all diagnoses</u>, answer the following:
Is the prescriber enrolled in the Thalomid REMS program? □ Yes □ No

For <u>cutaneous lupus,</u> also answer the following:
Is the prescriber a dermatologist? □ Yes □ No

Has the patient had a previous trial with an antimalarial medication such as hydroxychloroquine, chloroquine, or quinacrine?* □ Yes □ No
Please provide documentation.

For <u>gastrointestinal vascular malformation (Gastrointestinal angiodysplasia, Osler-Weber-Rendu syndrome),</u> also answer the following:
Does the patient have vascular malformations confirmed by endoscopic examination?* □ Yes □ No
Please provide documentation.

Does the patient have recurrent or refractory bleeding due to vascular malformation(s)? □ Yes □ No

Reauthorization:
If this is a reauthorization request, answer the following question:
Does patient have chart notes documenting a positive clinical response over the past 12 months?*□ Yes □ No
***Please submit chart notes documenting a positive clinical response.**

For <u>multiple myeloma/plasmacytoma</u>, also answer the following:
Select Thalomid's use below:
□ Induction therapy
□ Maintenance therapy

If being used for induction therapy, will Thalomid be used in combination with dexamethasone? □ Yes □ No
Does the patient have an absolute neutrophil count (ANC) of at least 1,000 cells/mm3? □ Yes □ No

Does the patient have a platelet count of at least 30,000/mm3? □ Yes □ No

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ Date: _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP – 4201
P.O. Box 64811
St. Paul, MN 55164-0811