

# THALOMID

## Prior Authorization Form

IF THIS IS AN URGENT REQUEST, Please Call UPMC Health Plan Pharmacy Services.

Otherwise please return completed form to:

UPMC HEALTH PLAN PHARMACY SERVICES

PHONE 800-979-UPMC (8762)

FAX 412-454-7722

**PLEASE TYPE OR PRINT NEATLY. Incomplete responses may delay this request.**

<b>Office Contact:</b>	<b>Provider Specialty:</b>
<b>Provider First Name:</b>	<b>Provider Last Name:</b>
<b>Provider Phone:</b>	<b>Provider Fax:</b>

<b>Patient Name:</b>	<b>Patient UPMC Health Plan ID Number:</b>	<b>Patient Age:</b>	<b>Patient DOB:</b>
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<b>Drug Requested:</b> <input type="checkbox"/> Brand <input type="checkbox"/> Generic	<b>Strength:</b>	<b>Frequency:</b>	<b>Expected length of therapy:</b>
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*Generic equivalent drugs will be substituted for Brand name drugs unless you specifically indicate otherwise.*

<input type="checkbox"/> New medication	If ongoing, provide date started:	If medication is ongoing, Did member Show improvement while on therapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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<b>Place of administration?</b> <input type="checkbox"/> Physician Office <input type="checkbox"/> Hospital/Facility Please provide facility/provider name and address:	<b>Please indicate how medication will be billed:</b> <input type="checkbox"/> Billed directly by the provider via JCODE Provide JCODE: _____ <input type="checkbox"/> Billed by a pharmacy and delivered to the provider <input type="checkbox"/> Billed by a pharmacy and delivered to the patient
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**Please provide pertinent progress notes and lab/radiology reports that describe the member's current disease status.**

Chart documentation enclosed       Chart documentation not available

**Please indicate the diagnosis and answer the corresponding questions:**

<input type="checkbox"/> Multiple Myeloma	Will Thalomid be used in combination with dexamethasone? If No, Why?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is Thalomid being used in combination with bortezomib (Velcade)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is Thalomid being used in combination with melphalan and prednisone?	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is patient eligible for transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Erythema Nodosum Leprosum (ENL)	Is Thalomid being used as acute treatment of cutaneous manifestations of moderate to severe erythema nodosum leprosum (ENL)	<input type="checkbox"/> Yes <input type="checkbox"/> No
	Is Thalomid being used as maintenance therapy for prevention and/or suppression of the cutaneous manifestations of ENL recurrence?	<input type="checkbox"/> Yes <input type="checkbox"/> No

<input type="checkbox"/> Other Diagnosis, please list:	Please provide clinical literature/studies to support request for off-label use. <input type="checkbox"/> Clinical literature/studies enclosed <input type="checkbox"/> Clinical literature/studies not available
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**Is Thalomid being used in combination with any other therapies?  Yes  No    If yes, please list below.**

Medication Name	Strength/Frequency	Dates of Therapy

**Please list below any other previous therapies tried:**

Medication Name	Strength/Frequency	Dates of Therapy	Reason for Discontinuation

**Please provide any additional information which should be considered in the space below:**
