Thalomid

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

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Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

ICD-10 Code: _____
Prescribed Drug and Dosage Form: _____
Is a loading dose required: ❑ Yes ❑ No
Prescribed Loading dose and duration: _____

Maintenance Dose and Frequency: _____

1. What is the patient's diagnosis?
   - ❑ Multiple myeloma
   - ❑ Erythema nodosum leprosum, *skip to #4*
   - ❑ Kaposi sarcoma
   - ❑ Multicentric Castleman disease
   - ❑ Histiocytic neoplasms
   - ❑ Myelofibrosis associated anemia, *skip to #4*
   - ❑ Crohn's disease, *skip to #4*
   - ❑ Chronic graft-versus-host disease, *skip to #4*
   - ❑ Aphthous stomatitis, *skip to #4*
   - ❑ Other _____
2. Is this a request for continuation of therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #6*
3. Is there evidence of disease progression or unacceptable toxicity while on the current regimen?
   ❑ Yes ❑ No *No further questions.*
4. Is this a request for continuation of therapy with the requested medication? ❑ Yes ❑ No *If No, skip to #6*
5. Does the patient have an improvement in symptoms and no unacceptable toxicity while on the current regimen?
   ❑ Yes ❑ No *No further questions.*
6. If the patient's diagnosis is listed below, *skip to the indicated question or no further questions*.
   - ❑ Multiple myeloma, *no further questions.*
   - ❑ Erythema nodosum leprosum, *no further questions.*
   - ❑ Kaposi sarcoma, *skip to #10*
   - ❑ Chronic graft-versus-host disease, *no further questions.*
   - ❑ Multicentric Castleman disease, *no further questions.*
   - ❑ Myelofibrosis associated anemia, *skip to #7*
   - ❑ Crohn's disease, *no further questions.*
   - ❑ Aphthous stomatitis, *skip to #13*
   - ❑ Histiocytic neoplasms, *skip to #11*
7. What is the prescribed regimen?
   - ❑ The requested medication in combination with prednisone
   - ❑ Other _____

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

8. What is the patient's serum erythropoietin (EPO) level?
   ❑ 500 mU/mL or greater, *no further questions.*
   ❑ Less than 500 mU/mL

9. Did the patient have no response or loss of response to erythropoiesis-stimulating agents?
   Indicate below and no further questions.
   ❑ No response ❑ Loss of response ❑ Other _____

10. What is the place in therapy in which the requested medication will be used?
    Indicate below and no further questions.
    ❑ First-line treatment ❑ Subsequent treatment

11. Will the requested medication be used to treat Langerhans cell histiocytosis or Rosai-Dorfman disease?
    ❑ Yes ❑ No

12. Will the requested medication be used as a single agent? ❑ Yes ❑ No *No further questions.*

13. What is the clinical setting in which the requested medication will be used?
    ❑ AIDS-related aphthous stomatitis
    ❑ Recurrent disease in immunocompromised patients
    ❑ Other _____

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature **Date (mm/dd/yy)**

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