

THALIDOMIDE AND DERIVATIVES

PRIOR AUTHORIZATION FORM

All agents in this class require prior authorization. To review the prior authorization guidelines, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – Thalidomide and Derivatives (accessible at: <http://www.dhs.state.pa.us/publications/bulletinsearch/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION

New Renewal Additional Information (PA#: _____)
pages in this request: _____ Office Contact Name: _____ Phone: (____) _____

RECIPIENT INFORMATION

Name: _____ Recipient ID#: _____ Date of Birth: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Specialty: _____
NPI#: _____ OR MA Provider ID#: _____ State License #: _____
Prescriber Address: _____ Suite #: _____
City/State/Zip: _____ Phone: (____) _____ Fax: (____) _____
Long-term care facility (if applicable) contact name: _____ Phone: (____) _____

MEDICAL INFORMATION

Medication Requested:

Pomalyst Revlimid Thalomid

Strength: _____ Directions: _____ Quantity: _____ Refills: _____

Diagnosis: _____ – submit documentation (e.g., chart notes, lab results, biopsy results)

Diagnosis Code: _____ (required)

Specialty Pharmacy Drug Program:

Which Specialty pharmacy will be used? Diplomat Specialty Pharmacy Walgreens Specialty Pharmacy

Renewal Request

Since the requested medication was initiated, has the Recipient experienced a positive clinical response?

Yes – submit documentation No

PLEASE FAX COMPLETED FORM WITH CLINICAL INFORMATION TO DHS – PHARMACY DIVISION

Prescriber Signature: _____ Date: _____

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