CareFirst
The CareFirst BlueCross BlueShield family of health care plans

Thalomid® – Prior Authorization Request (For Maryland Only)

Send completed form to: Case Review Unit CVS/caremark Specialty Programs Fax: 866-249-6155

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 866-249-6155**. If you have questions regarding the prior authorization, please contact CVS/caremark at **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® 800-237-2767.

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

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-Based practice guidelines.

1. What drug is being prescribed? ☐ Thalomid® ☐ Other _____

2. What is the prescribed dose per day? _____ mg/day

3. What is the patient's diagnosis?
   - ☐ Erythema nodosum leprosum (ENL)
   - ☐ Systemic light chain amyloidosis
   - ☐ Behcet's syndrome
   - ☐ AIDS-related diarrhea
   - ☐ HIV-related aphthous ulcer of mouth or esophagus
   - ☐ Cancer-related cachexia
   - ☐ Chronic graft versus host disease
   - ☐ Myelofibrosis with myeloid metaplasia
   - ☐ Waldenström's macroglobulinemia / lymphoplasmacytic lymphoma
   - ☐ Myeloma or progressive solitary plasmacytoma☐
   - ☐ Other _____

4. What is the ICD code? _____

5. Would the prescriber like to request an override of the step therapy requirement? ☐ Yes ☐ No If no, skip to #8.

6. Has the member received the medication through a pharmacy or medical benefit within the past 180 days? ☐ Yes ☐ No
   ACTION REQUIRED: Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e., PBM medication history, pharmacy receipt, EOB etc.)

7. Is the medication effective in treating the member's condition? ☐ Yes ☐ No
   Continue to #8 and complete this form in its entirety.

8. How will Thalomid® be used?
   - ☐ Monotherapy / Single agent
   - ☐ Dexamethasone
   - ☐ Dexamethasone and cyclophosphamide
   - ☐ Rituximab (Rituxan)
   - ☐ Dexamethasone and bortezomib (Velcade)
   - ☐ Melphalan **and** prednisone
   - ☐ Dexamethasone, cisplatin, doxorubicin, cyclophosphamide, and etoposide (DT-PACE)
   - ☐ Other _____

Complete the following section based on patient's diagnosis

Section A: Multiple Myeloma

9. Is Thalomid being used as:
   - □ Primary therapy
   - □ Maintenance therapy, no further questions
   - □ Salvage therapy, skip to #11

10. If being used as primary therapy, is the member eligible for stem cell transplant? □ Yes □ No *No further questions*

11. If being used as salvage therapy, will the Thalomid be used as part of the same chemotherapy regimen as their primary therapy? □ Yes □ No *If no, no further questions.*

12. Was the patient a transplant candidate? □ Yes □ No

Section B: Cachexia

13. Is the cachexia due to HIV infection or cancer? □ Yes □ No

Section C: Kaposi's Sarcoma

14. Does the patient have an HIV infection? □ Yes □ No

Section D: Graft-versus-Host Disease

15. Has the patient received a bone marrow transplant? □ Yes □ No

16. Is Thalomid being used as:
   - □ Treatment of chronic or recurrent graft-versus-host disease
   - □ Prophylaxis of chronic or recurrent graft-versus-host disease
   - □ Other _____

17. Was the disease refractory to other therapies? □ Yes □ No

Section E: Crohn's Disease

18. Did the patient have a previous failure of, or intolerance to, standard therapies (e.g., corticosteroids, sulfasalazine [Azulfidine], azathioprine [Azasan, Imuran])? □ Yes □ No

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)**