

PHYSICIAN PRIOR AUTHORIZATION REQUEST FORM BlueCross BlueShield of South Carolina

Patient Information	
Name:	Insurance ID #:
Group#:	Birthdate:
Provider Information	
Physician's Name:	Physician DEA #:
Phone:	Fax:
Office Address:	
Diagnosis:	ICD-9 Code:

When this form is completed, please fax to Caremark at 1-888-836-0730.

This fax machine is located in a HIPAA-compliant, secure location.

Call Caremark at 1-800-294-5979 with any questions concerning prior authorization procedures.

When conditions are met, we will authorize the coverage of Thalomid (Medicare Prior Authorization)

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| 1. Does the patient have a diagnosis of multiple myeloma? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 2. Will Thalidomide be used in combination with dexamethasone? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 3. Does the patient have a diagnosis of advanced, refractory multiple myeloma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does the patient have a diagnosis of moderate to severe erythema nodosum leprosum (also known as ENL, Hansons disease, or leprosy)? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 5. Does the patient suffer from moderate to severe neuritis associated with ENL? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 6. Will the patient be treated with thalidomide as monotherapy? | <input type="checkbox"/> Y | <input type="checkbox"/> N |
| 7. Is the prescriber registered in the System for Thalidomide Education and Prescribing Safety (S.T.E.P.S) program? | <input type="checkbox"/> Y | <input type="checkbox"/> N |

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8. Has the patient or his/her parent or legal guardian signed an informed consent form? Y N
9. Is the patient a female? Y N
10. Is the patient of child bearing potential? Y N
11. Has pregnancy been excluded as confirmed by two negative urine or serum pregnancy tests? Y N
12. Has the patient been instructed on appropriate contraceptive methods for thalidomide use? Y N
13. Has the patient been informed of the need to be observant for the signs and symptoms of thromboembolism [e.g., shortness of breath, chest pain or arm or leg swelling.]? Y N

Comments: _____

Information on this form is accurate as of the date below.

Prescriber's Signature:	Date:
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