BlueCross BlueShield Federal Employee Program

THALOMID
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Thalomid (thalidomide)

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

NOTE: Form must be completed in its entirety for processing

Is this request for brand or generic? ❑Brand ❑Generic

What is the patient's total daily dose (mg per day) of Thalomid? _____ mg per day

1. What is the patient's diagnosis?
   ❑Castleman disease ❑Kaposi sarcoma ❑Langerhans cell histiocytosis ❑Myelofibrosis ❑Rosai-Dorfman disease
   ❑Erythema Nodosum Leprosum (ENL)
   a. Is Thalomid being used for the acute treatment of the cutaneous manifestations of moderate to severe ENL? ❑Yes ❑No*
   If NO, is Thalomid being used as maintenance therapy for prevention and suppression of the cutaneous manifestations of ENL? ❑Yes ❑No
   ❑Multiple Myeloma (MM)
   a. Will Thalomid be used in combination with dexamethasone? ❑Yes ❑No
   b. Has the patient been on Thalomid continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the following question(s):
   i. Is the patient's multiple myeloma newly diagnosed? ❑Yes ❑No*
   If NO, does the patient have relapsed or progressive multiple myeloma? ❑Yes ❑No
   ❑**YES** - this is a PA renewal for **CONTINUATION** of therapy, please answer the following question:
   i. Has the patient experienced disease progression or unacceptable toxicity while on Thalomid? ❑Yes ❑No
   ❑Other diagnosis ***(please specify)***: _____
2. Does the prescriber agree to monitor for signs and symptoms of thromboembolism? ❑Yes ❑No
3. **MALE Patient**: Does the patient have a female partner of reproductive potential? ❑Yes* ❑No
   If YES, will the patient be advised to use a latex or synthetic condom during any sexual contact while on treatment with Thalomid and for four weeks after the last dose, even if they have undergone a successful vasectomy? ❑Yes ❑No
4. Are both the patient and prescriber enrolled and compliant with the Thalomid REMS program? ❑Yes ❑No
5. Has the patient been on Thalomid continuously for the last **6 months**, excluding samples? ***Please select answer below:***
   ❑**NO** – this is **INITIATION** of therapy, please answer the following question(s):
   a. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes* ***(*If YES, please answer the questions below)*** ❑No
   i. Has the patient had **TWO** negative pregnancy tests before the initiation of Thalomid? ❑Yes ❑No
   ii. Will the patient be advised to abstain continuously from heterosexual sexual intercourse or to use **TWO** methods of reliable birth control simultaneously for four weeks prior to initiation of Thalomid, during therapy, during dose interruptions, and continuing for four weeks following the last dose? ❑Yes ❑No
   ❑**YES** - this is a PA renewal for **CONTINUATION** of therapy, please answer the following question(s):
   a. **FEMALE Patient**: Is the patient of reproductive potential? ❑Yes* ❑No
   If YES, will the patient be advised to abstain continuously from heterosexual sexual intercourse or to use **TWO** methods of reliable birth control simultaneously during therapy, during dose interruptions, and for four weeks after the last dose? ❑Yes ❑No

BlueCross BlueShield
Federal Employee Program

THALOMID
PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***