CVS CAREMARK

Fax Referral To: 800-323-2445

Phone: 866-278-6634

Thalomid® (thalidomide)
Enrollment Form
For Blue Cross Blue Shield of Rhode Island Members

Date: _____ **Needs by Date (Please Specify):** _____

Ship to: ☐ **Patient** ☐ **Office** ☐ **Other:** _____

PATIENT INFORMATION

*(Complete the following or **send patient demographic sheet**)*

Patient Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Alternate Phone: _____
SS #: _____
Insurance ID: _____
Date of Birth: _____ Gender: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____
State License #: _____ UPIN: _____
DEA #: _____ NPI #: _____
Group or Hospital: _____
Address: _____
City, State Zip: _____
Phone: _____ Fax: _____
Contact Person: _____
Contact Phone: _____

INSURANCE INFORMATION *(If available, please copy and attach the front and back of insurance and prescription drug card)*

Primary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: **Blue Cross Blue Shield of RI**

Secondary Insurance: Subscriber: _____ Subscriber ID#: _____ Name of Insurer: _____

STATEMENT OF MEDICAL NECESSITY

Diagnosis (ICD-9 code): ☐ 695.2 Erythema Nodosum (ENL) ☐ Other: _____ • Date of Diagnosis: _____

APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY.

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

• Is the patient pregnant? ☐ Yes ☐ No

Thalomid may be approved if the diagnosis is one of the following approved by the Food and Drug Administration (FDA):

• The patient has an indication of Erythema nodosum leprosum (ENL) treatment ☐ Yes ☐ No
• The patient has an indication of Erythema nodosum leprosum (ENL) suppression ☐ Yes ☐ No
• The patient has an indication of Multiple Myeloma in combination with dexamethasoneme ☐ Yes ☐ No

The patient has one of the following diagnosis that is recognized in a major compendium:

• Behcet's syndrome ☐ Yes ☐ No
• Hlzg V associated wasting syndrome ☐ Yes ☐ No
• Aphthous stomatitis treatment ☐ Yes ☐ No
• Esophageal aphthous ulcers in HIV-infected patients ☐ Yes ☐ No

Note: Requests for greater than 400mg/day require a letter submitted by the physician which include member name, identification number, diagnosis, agent needed, dosage, and an explanation why greater than max allowed dose is needed.

Note: The following compendia, American Hospital Formulary Service, U.S. Pharmacopeia Dispensing Information, National Comprehensive Cancer Network NCCN), and Drug & Biologics Compendium™ Category of Evidence and Consensus are considered during prior authorization review if the drug is being prescribed for a condition not listed above. Additional information may be requested if documentation in the compendia is lacking.

Medical Necessity (please attach all supporting documentation):

_____

_____

PRESCRIPTION INFORMATION

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Thalomid® (thalidomide)	☐ 50mg ☐ 100mg ☐ 150mg ☐ 200mg	☐ Take 200mg (one capsule) by mouth once a day with water ☐ Other: _____	☐ 4-week supply _____50mg _____100mg _____150mg _____200mg	

PRODUCT SUBSTITUTION PERMITTED (Date) DISPENSE AS WRITTEN (Date)

IMPORTANT NOTICE: *This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should such material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. Thalomid PAB 092908*