



Prescription Drug Coverage Determination Form
 Leprostatic
 Thalomid® (thalidomide)

Please fax the completed form to Mercy Health Plans' Pharmacy Department
 at 314-214-8201 or 1-800-647-2240.

Patient Information

Patient Name: _____ Date of Birth: _____
 Subscriber ID#: _____
 Address _____ City _____ State _____ Zip Code _____

Physician Information

Name: _____ Specialty: _____ Tax ID#: _____
 Office Address _____ City _____ State _____ Zip Code _____
 Telephone: _____ Fax: _____ Contact Person _____

Physician Signature (REQUIRED): _____ Date _____

Medication Information (requests for non-formulary agents will be considered for members having a documented failure or contraindication to preferred agents.)

Medication name: _____ J-code: _____
 Dose: _____ Directions: _____
 Expected Duration of Therapy: _____

Prior Authorization Criteria:	
1. Does the patient have a newly diagnosed multiple myeloma?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Does the patient have a diagnosis of advanced, refractory multiple myeloma?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes:	
▪ Will thalidomide be used in combination with dexamethasone?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Does the patient have a diagnosis of moderate to severe erythema nodosum leprosum (also known as ENL, Hanson's disease, or leprosy)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes:	
▪ Does the patient suffer from moderate to severe neuritis associated with ENL?	<input type="checkbox"/> Yes <input type="checkbox"/> No
▪ Will the patient be treated with thalidomide monotherapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Is the patient a female of childbearing potential?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes:	
▪ Has pregnancy been excluded by 2 negative urine or serum pregnancy tests?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has the patient been instructed on the importance and proper utilization of appropriate contraceptive methods for thalidomide use?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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| 6. Is the prescriber registered in the System for Thalidomide Education and Prescribing Safety (S.T.E.P.S)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Has the patient or legal signed an informed consent form? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Please provide any additional history or medical information that may support coverage (attach office notes as necessary): _____

Note: If approved coverage will be as specified in above criteria or through the end of the year (December 31, 20xx). Some medications may be subject to quantity limitations or restricted to certain pharmacies.