



Date of Request: _____

Sterling Retiree Rx Prior Authorization Form

THALOMID (Thalidomide)

Coverage Criteria

Newly diagnosed or advanced refractory Multiple Myeloma (MM) – patient must be receiving combination therapy with dexamethasone; moderate to severe Erythema Nodosum Leprosum (ENL) – Thalomid cannot be used as monotherapy in patients with moderate to severe neuritis.

Required Medical Information

If female of child bearing potential, pregnancy ruled out by 2 negative urine or serum pregnancy tests.

Exclusion Criteria

Pregnancy; non FDA approved use

Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physician Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			

Requested Drug

THALOMID	Reason for Request	
Condition/Diagnosis Related		

Clinical Drug/Lab History Pertinent to Request

Labs: Baseline/Ongoing	Strength/Dosage			
Formulary Alternative(s) Attempted?	Yes:		No:	
Please List Alternative Formulary Drugs				

Comments					
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Physician Signature _____ FAX FORM to 1-877-847-9904