



Thalomid (thalidomide)

Prior Authorization Form Curascript Fax (888) 773-7386

Form with fields: Last Name, First Name, Prescriber's Name, Specialty, Home Phone, Work Phone, Office Phone, Office Fax, Home Address, City, State, ZIP, Address, City, State, ZIP, SCAN ID number, Date of Birth, Est. Start Date, Office Contact, For Specialty Medications Only: Shipping Address (if different from home address) [] Physician [] Home, Special Instructions (i.e. Non-English Speaking Patient, etc.):

Medication: Diagnosis: Sig: Qty: Refills: ICD 9 Code:

Secondary/ Supplemental Insurance Company Phone Name of Insured ID Number Group Number

1. Was the initial prescription written or recommended by an Oncologist or Hemotologist?
2. Is the patient diagnosed with Multiple Myeloma?
3. Is the diagnosis or indication for the treatment of Erythema Nodosum Leprosum (ENL)?
4. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?

Physician's Signature: _____ NPI/DEA #: _____ Date: _____

For Internal Use Only
[] Approved [] Denied
Reviewer's Initials _____ Decision Date _____
Comments _____