Thalomid
(thalidomide)

Prior Authorization Form
Curascript
Fax (888) 773-7386

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	
VH 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?**

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: ______________

<u>For Internal Use Only</u>
☐ Approved ☐ Denied Reviewer's Initials __________________ Decision Date ___________________
Comments____

Notice: **Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information.** Our