Prescriber Criteria Form

Thalomid 2025 PA Fax 230-A v1 010125.docx
Thalomid (thalidomide)
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Thalomid (thalidomide).

Drug Name:
Thalomid (thalidomide)

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Does the patient have a diagnosis of multiple myeloma? [If yes, then no further questions.]	Yes ◯	No ◯
2	Does the patient have a diagnosis of erythema nodosum leprosum? [If yes, then no further questions.]	Yes ◯	No ◯
3	Does the patient have a diagnosis of multicentric Castleman's disease? [If yes, then no further questions.]	Yes ◯	No ◯
4	Does the patient have a diagnosis of acquired immunodeficiency syndrome (AIDS)-related aphthous stomatitis? [If yes, then no further questions.]	Yes ◯	No ◯
5	Does the patient have a diagnosis of myelofibrosis-associated anemia? [If yes, then no further questions.]	Yes ◯	No ◯
6	Does the patient have a diagnosis of Kaposi sarcoma? [If yes, then no further questions.]	Yes ◯	No ◯
7	Does the patient have a diagnosis of ANY of the following histiocytic neoplasms: A) Rosai-Dorfman disease, B) Langerhans Cell Histiocytosis?	Yes ◯	No ◯

Comments:	_____

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.
Prescriber (or Authorized) Signature: _____ Date:_____