



Prescription Drug Coverage Determination Form
Leprostatic
Thalomid® (thalidomide)

Please fax the completed form to Mercy Health Plans' Pharmacy Department at 314-214-8201 or 1-800-466-9854.

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. Is the medication being requested to treat an FDA-approved indication not otherwise excluded from Part D?
2. Does the patient have a diagnosis multiple myeloma?
3. Does the patient have a diagnosis of moderate to severe erythema nodosum leprosum (also known as ENL, Hanson's disease, or leprosy)?
4. Is the patient a female of childbearing potential?

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|---|------------------------------|-----------------------------|
| 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 |
| 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.