pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

THALIDOMIDE AND DERIVATIVES PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Thalidomide and Derivatives** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	Total # of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
Facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Medication requested: ***(All listed medications are preferred with clinical prior authorization required.)***		☐Pomalyst ☐Revlimid ☐Thalomid
Directions:		
Strength & dosage form:	Quantity:	Refills:
1. What is the beneficiary's diagnosis?		*Submit documentation confirming diagnosis, such as chart notes, lab results, biopsy results, etc.*
2. What is the corresponding diagnosis code?		
3. Most oral oncology agents are included in the Department's Specialty Pharmacy Drug Program (SPDP). Which specialty pharmacy will be used? (Refer to the Department's SPDP website for more information: http://www.dhs.pa.gov/provider/pharmacyservices/thespecialtypharmacydrugprogram/index.htm.)		☐Diplomat Specialty Pharmacy ☐Walgreen's Specialty Pharmacy
4. ***For renewal requests only***, since the requested medication was started, has the Beneficiary experienced a positive clinical response to therapy?		☐Yes – *Submit documentation of Beneficiary's response to therapy.* ☐No

PLEASE FAX COMPLETED FORM WITH SUPPORTING CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date:**