| Prescriber Criteria Form<br><br>Thalomid 2024 PA Fax 230-A v1 010124.docx<br>Thalomid (thalidomide)<br>Coverage Determination |
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| This fax machine is located in a secure location as required by HIPAA regulations.<br>Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673**.<br>Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process.<br>When conditions are met, we will authorize the coverage of Thalomid (thalidomide). |

| Drug Name:<br>Thalomid (thalidomide) |
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| **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 ANY of the following diagnoses: A) multiple myeloma, B) erythema nodosum leprosum, C) multicentric Castleman's disease, D) acquired immunodeficiency syndrome (AIDS)-related aphthous stomatitis, E) chronic graft-versus-host disease, F) Crohn's disease, G) myelofibrosis-associated anemia, H) Kaposi sarcoma?<br>[If yes, then no further questions.] | Yes | No |
| 2 | 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. |
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| **Prescriber (or Authorized) Signature:** _____ **Date:**_____ |