**PRIORITY PARTNERS**
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

# Prior Authorization

JOHNS HOPKINS HEALTH PLANS (MEDICAID)

Thalomid - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**. Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Thalomid - Priority Partners MCO.

Drug Name (select from list of drugs shown)
Thalomid (thalidomide)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

**Diagnosis:** _____ **ICD Code:** _____

Comments: _____

**Please circle the appropriate answer for each question.**

1. Has the plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

NOTE: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.

[If yes, skip to question 11.]

2. Does the patient have a diagnosis of multiple myeloma? Y N

NOTE: Submission of medical records is required

| | | |
|---|---|---|
| | [If no, skip to question 7.] | |
| 3. | Will the requested drug be used concurrently with dexamethasone? | Y N |
| | NOTE: Submission of medical records is required | |
| | [If no, no further questions.] | |
| 4. | Will the patient receive concurrent aspirin, warfarin or low molecular weight heparin due to the high risk of thromboembolism? | Y N |
| | NOTE: Submission of medical records is required | |
| | [If yes, skip to question 6.] | |
| 5. | Does the patient have absolute contraindication to antithrombotic therapy? | Y N |
| | NOTE: Submission of medical records is required | |
| | [If no, no further questions.] | |
| 6. | Is the patient 18 years of age or older? | Y N |
| | [If yes, skip to question 10.] | |
| | [If no, no further questions.] | |
| 7. | Does the patient have a diagnosis of acute cutaneous manifestations of moderate to severe erythema nodosum leprosum (ENL)? | Y N |
| | NOTE: Submission of medical records is required | |
| | [If yes, skip to question 9.] | |
| 8. | Will the requested medication be used for prevention and suppression of the cutaneous manifestations of ENL recurrence? | Y N |
| | NOTE: Submission of medical records is required | |
| | [If no, no further questions.] | |
| 9. | Is the patient 12 years of age or older? | Y N |
| | [If no, no further questions.] | |
| 10. | Will the requested drug be given at the guideline-recommended dosage? | Y N |
| | [No further questions.] | |
| 11. | Will the requested drug be given at an efficient dose to maximize patient adherence and cost-effective therapy? | Y N |
| | NOTE: Submission of medical records is required | |

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

| **Prescriber (Or Authorized) Signature and Date** |
| --- |