Thalidomide (Thalomid®)

PRIOR REVIEW/CERTIFICATION FAXBACK FORM

INCOMPLETE FORMS MAY DELAY PROCESSING
ALL NC PROVIDERS MUST PROVIDE THEIR 5-DIGIT BCBSNC PROVIDER ID# BELOW

PRESCRIBER INFORMATION		PATIENT INFORMATION	
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME	
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID	
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH	
PRACTICE ADDRESS	CITY	STATE	ZIP

Please answer the following questions: **Dx Code:_____________**

For which of the following conditions is thalidomide being prescribed? ***Please check the appropriate box below:***

☐ Treatment of multiple myeloma in combination with dexamethasone

☐ Erytherma nodosum leprosum (ENL)**:** acute and maintenance therapy for cutaneous manifestations of ENL

☐ Erytherma nodosum leprosum (ENL) with moderate to severe neuritis and is receiving concurrent corticosteroid treatment.

☐ Crohn's disease in a patient who has previously taken at least one of the following agents (corticosteroid, 5-aminosalicylate, azathioprine, 6-mercaptopurine, metronidazole, methotrexate, TNF inhibitors) and experienced an inadequate response

☐ Treatment of aphthous ulcers associated with HIV/AIDS disease.

☐ Other. Please attach medical records.

Please certify the following by signing and dating below:

I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

Prescriber's Signature (Required):_____________________________________Date:_________________

For BCBSNC members, fax form to 1-800-795-9403