Immune Modulators: Thalidomide Analogues

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision. Allow at least 24 hours for review.

Apple Health Preferred Drug list: https://www.hca.wa.gov/assets/billers-and-providers/apple-health-preferred-drug-list.xlsx

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No **If yes, what is this member's due date? _____**

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

United Healthcare Community Plan

Immune Modulators: Thalidomide Analogues

1. Is this request for a continuation of therapy ? ☐ Yes ☐ No
   If yes, does patient have clinical documentation of a response to treatment defined by improvement or stabilization of disease or symptoms? ☐ Yes ☐ No

2. Indicate patient's diagnosis:
   - ☐ Erythema nodosum leprosum (ENL)
   - ☐ Follicular lymphoma
   - ☐ Kaposi sarcoma
   - ☐ POEMS syndrome
   - ☐ Other. Specify:
   - ☐ Mantle cell lymphoma (MCL)
   - ☐ Marginal zone lymphoma (MZL)
   - ☐ Multiple myeloma (MM)
   - ☐ Myelodysplastic syndrome (MDS)

3. Is this prescribed by or in consultation with any of the following? Check all that apply:
   - ☐ Infectious disease specialist
   - ☐ Hematologist
   - ☐ Dermatologist
   - ☐ Oncologist
   - ☐ Other. Specify:

4. Will the requested drug be used in combination with any of the following? Check all that apply:
   - ☐ Corticosteroids
   - ☐ Prednisone
   - ☐ Rituximab
   - ☐ Other. Specify:
   - ☐ Dexamethasone
   - ☐ Obinutuzumab
   - ☐ None, monotherapy

5. Has patient previously been treated with any of the following? Check all that apply:
   - ☐ Bendamustine + rituximab
   - ☐ Lenalidomide
   - ☐ Cyclophosphamide/doxorubicin/vincristine/prednisone
   - ☐ Rituximab/cyclophosphamide/doxorubicin/vincristine/prednisone
   - ☐ Rituximab/cyclophosphamide/vincristine/prednisone
   - ☐ Bendamustine + rituximab/obinutuzumab
   - ☐ Proteosome inhibitor (e.g., bortezomib)

6. List all other treatment regimens the patient has tried, if any:

Specify:

<u>For diagnosis of Erythema Nodosum Leprosum (ENL), complete the following:</u>

7. Will the medication be used for the acute treatment of the cutaneous manifestations of moderate to severe ENL?
   ☐ Yes ☐ No

8. Is moderate to severe neuritis present? ☐ Yes ☐ No

9. Will the medication be used as maintenance therapy for prevention and suppression of the cutaneous manifestations of ENL recurrence? ☐ Yes ☐ No

<u>For diagnosis of Follicular Lymphoma (FL) complete the following:</u>

10. Is the requested medication being used as a first-line treatment? ☐ Yes ☐ No

United Healthcare Community Plan

Immune Modulators: Thalidomide Analogues

For diagnosis of Kaposi Sarcoma complete the following:

11. Has patient progressed on at least one prior systemic treatment (e.g. liposomal doxorubicin or paclitaxel) unless contraindicated? ☐ Yes ☐ No

12. Is patient HIV-positive? ☐ Yes ☐ No
    If yes, will patient remain on highly active antiretroviral therapy? ☐ Yes ☐ No

For diagnosis of Marginal Zone Lymphoma (MZL) complete the following:

13. Is the requested medication being used as a first-line treatment? ☐ Yes ☐ No

For diagnosis of Multiple Myeloma complete the following:

14. Indicate the following for the medication requested:
    ☐ Lenalidomide (Revlimid)
    - Is the requested medication being used as a maintenance therapy? ☐ Yes ☐ No

    ☐ Pomalidomide (Pomalyst)
    Has patient demonstrated disease progression on or within 60 days of completion of last therapy?
    ☐ Yes ☐ No

For diagnosis of Myelodysplastic Syndrome (MDS) complete the following:

15. Does patient have a lower risk disease as defined by IPSS? (e.g. IPSS Low or Intermediate-1; IPSS-R Very Low, Low, Intermediate; WPSS Very Low, Low, Intermediate) ☐ Yes ☐ No

16. Does patient have transfusion-dependent anemia defined as two or more units of red blood cells in the previous eight weeks? ☐ Yes ☐ No

17. Indicate the following for patient:
    ☐ MDS with del(5q) abnormality
    ☐ MDS without del(5q) abnormality
    ☐ Serum erythropoietin levels are less than 500 mIU/mL
    - Does patient have history of inadequate response to erythropoiesis stimulating agents (ESA) with or without granulocyte colony stimulating factor (G-CSF)? ☐ Yes ☐ No

    ☐ Serum erythropoietin levels are greater than 500 mIU/mL
    - Does patient have a history of intolerance, contraindication, or failure to immunosuppressive therapy? (e.g. anti-thymocyte globulin ± cyclosporine A) or demethylating agents (e.g. azacitidine or decitabine) ☐ Yes ☐ No
    - Does patient have verified SF3B1 mutation?
      ☐ Yes ☐ No

For diagnosis of POEMS Syndrome complete the following:

18. Does patient have any of the following? Check all that apply:
    ☐ Disseminated disease (e.g. more than 3 bone lesions) and is not a candidate for radiation-only therapy
    ☐ Patient is not a candidate for autologous hematopoietic cell transplantation (HCT)

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CHART NOTES ARE REQUIRED WITH THIS REQUEST		
Prescriber signature	Prescriber specialty	Date